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Title: REQUEST FOR RECONSIDERATION AFTER FINAL ACTION.

Part 1 of 1

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OMB No. 0651-.... (Exp. 08/31/2004)

Request for Reconsideration after Final Action

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SERIAL NUMBER	77857591
LAW OFFICE ASSIGNED	LAW OFFICE 111
MARK SECTION (no change)	
ARGUMENT(S)	

IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

In the Application of Sierra Tucson, Inc.

Serial Number: 77857591

Mark: **EMDR INTENSIVES**

International Class: 44

Examining Attorney: Nakia D. Henry

Law Office: 111

Commissioner for Trademarks

P O Box 1451

Alexandria, VA 22313-1451

REQUEST FOR RECONSIDERATION

AND NOTICE OF APPEAL

Applicant submits the following remarks and evidence in response to the Office Action electronically transmitted September 1, 2011.

DISCLAIMER

The Examining Attorney accepted Applicant's disclaimer of the term EMDR, thus agreeing that the term EMDR is at the least merely descriptive, and more appropriately, a generic acronym for the phrase "Eye Movement Desensitization and Reprocessing" as a Attached hereto are numerous references to the EMDR technique, used by many multiple parties unrelated to the cited Registrant. (See Wikipedia entry, Aetna clinical advisory, government and professional adoption of use of EMDR techniques, unrelated third party clinicians) As such, no single entity or person can claim any exclusive right to use the term EMDR.

NOTICE OF APPEAL AND REQUEST FOR SUSPENSION PENDING CANCELLATION PROCEEDING

AGAINST REGISTRATION NO.: 1986652 and 1808113.

Applicant has concurrently filed an appeal of the Examining Attorney's decision, and if this request for reconsideration is not traversed, then Applicant requests suspension of the appeal pending the outcome of its concurrently filed Petition for Cancellatiom

LIKELIHOOD OF CONFUSION

The Examining Attorney has refused registration of Applicant's mark, **EMDR INTENSIVES** (shown below) under Trademark Action Section 2(d), 15 U.S.C. Section 1052(d), stating that Applicant's mark, when used on or in connection with the identified goods, so resembles the marks in U.S. Registration Nos. 3369419, and 2117226, 1986652 and 1808113 as to be likely to cause confusion, to cause mistake, or to deceive.

Applicant respectfully disagrees with the Examining Attorney as to a likelihood of confusion between its mark and the cited marks. Applicant asserts that there is sufficient difference between its mark and the cited marks so that confusion is not likely. As such refusal relates to Registration No.: 3369419 for EMDRIA EDMR INTERNATIONAL ASSOCIATION (and stylized Design), the Registration has specifically disclaimed any exclusive right to use the term EMDR, and as such, such registration cannot form the basis of rejection by the Examining Attorney. Applicant has applied to register its mark EDMR INTENSIVES for the services, "psychological assessment services, psychological consultation, psychological counseling, psychological testing and psychological tests," in International class 44. Cited Registration No. 3369419 is for the mark EMDRIA EMDR International Association and Design for "association services, namely promoting the interests of clinical and research psychologists". In its application to register the association services mark, the Registrant went to great lengths to distance itself from the offering of psychological services and instead, differentiated its services as an international association for practitioners utilizing the disclaimed EMDR therapy. (See file history response to official action) Applicant's mark is different when visually and orally compared in their entireties. The examining attorney cannot arbitrarily dissect the marks and compare the marks specifically, the disclaimed portion of the marks) to find that the marks are confusingly similar. Registrant's mark EMDRIA EMDR INTERNATIONAL ASSOCIATION (along with graphical elements) and Applicant's mark is EMDR INTENSIVES. The marks are completely different, pronounced different and but for the disclaimed portion, would have no similarity whatsoever. Applicant requests reconsideration of this registration as a basis for rejection. The remaining marks are owned by EMDR Institute, Inc. and are the subject of a concurrently filed petition for cancellation by Applicant.

Registration No. 2117226 is for the mark EMDR INSTITUTE, INC. for "educational services, namely seminars, workshops, classes and training in the field of psychology and psychotherapy" and psychological testing and consultation services and psychotherapy services; and cited Registration No. 1986652 is for the mark EMDR for "educational services in the field of psychological testing and consultation services and psychotherapy services and educational services in the field of psychology and psychotherapy" and last, Registration No.: 1808113 is for "educational services for professionals in the field of mental health." Each of the cited registrations are owned (or consented to) by the person who developed the EMDR technique, Ms. Francine Shapiro. However, she has used and continues to use this descriptive acronym to describe the actual technique used in conjunction with mental health therapy, or Eye Movement Desensitization and Reprocessing. This technique is widely referenced by its descriptive acronym in the mental health industry, and is used generically to reference such technique. See all attached third party usage. No single entity or person can effectively claim the exclusive right to use this admittedly generic phrase, nor the acronym widely used to reference the descriptive phrase, something the examiner has recognized by her requirement that the phrase and acronym be disclaimed. While Ms. Shapiro may have invented the technique, its generic usage in the phsychological testing industry and lack of singular ownership means that Applicant likewise has no right to claim any exclusive right to the acronym EMDR. The mark EMDR merely identifies a process or system; it does not function as a service mark to identify and distinguish Registrant's services from those of others and to indicate the source of Registrant's services. Trademark Act Sections 1, 2, 3 and 45, 15 U.S.C. §§1051-1053, 1127; *see In re Universal Oil Prods. Co.*, 476 F.2d 653, 655-56, 177 USPQ 456, 457 (C.C.P.A. 1973) (holding the wording PACOL as used on the specimen is the name of a direct catalytic dehydrogenation process and does not identify the services in the application, "research, development, evaluation, market and economic studies, consultation, design, engineering, and technical services," in connection with the identified process; the wording PENEX as used on the specimen is the name of a continuous catalytic isomerization process and also does not identify similar services in the application); TMEP §§904.07(b), 1301.02(e). A process or system is a way of doing something, and is not generally a service. Thus the name of a system or process does not function as a service mark unless it is also used to indicate the exclusive source of the services. *In re Hughes Aircraft Co.*, 222 USPQ 263, 264 (TTAB 1984); TMEP §1301.02(e). Determining whether matter functions solely as the name of a system or process and also as a service mark is based on the manner in which the mark is used in commerce. *In re Hughes Aircraft*, 222 USPQ at 264; TMEP§1301.02(e). In this case, the plethora of evidence shows the applied-for mark used solely to identify a process or system because wherever EDMR is used, it identifies a psychological technique or method. For example, the Registrant's website includes a statement specifically stating that it has no affiliation with various groups utilizing the name EMDR in its reference list, namely: "These organizations are not affiliated with the EMDR Institute or Francine Shapiro, PhD." The term EMDR is now recognized all over the world as a very effective technique using Eye Movement Desensitizing and Reprocessing (with some clinical reservations, as noted on in several of the attached articles) for treating post-traumatic stress. Registrant itself recognizes the generic usage of the acronym for trauma treatment, and not just trauma treatment associated with Registrant's services. Registrant states " Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories

(Shapiro, 1989a, 1989b)."

In fact, the prior Registrant has a distinctiveness limitation statement for Registration No.: 2117226

specifically limiting the acronym EMDR. As such, and in view of such widespread industry use of the acronym EMDR in a generic mannerfor a specific mental health technique, Applicant respectfully submits that the Examining Attorney has improperly dissected its mark. Applicant's mark consists of the clearly descriptive letters EMDR combined with the word INTENSIVES. Applicant respectfully maintains that the similarity of the marks, if any, is minimal. First, Applicant respectfully submits that the literal element of its mark is not just the generic acronym EMDR but rather, "EMDR INTENSIVES." Applicant contends that the differences in the marks far outweighs any point of similarity. Several marks that had common or similar elements have avoided a finding of likelihood of confusion. See, e.g., *Mr. Hero Sandwich Systems, Inc. v. Roman Meal Co.*, 228 USPQ 364 (CA FC 1986) (ROMAN and ROMANBURGER were not confusingly similar), and *Bell Laboratories, Inc. v. Colonial Products, Inc.*, 231 USPQ 569 (DC S Fla 1986) (FINAL FLIP and FINAL, for pesticides, were not confusingly similar). Applicant's mark creates a distinguishable appearance from the cited marks, and when properly compared in their entireties, Applicant's mark gives a distinct and distinguishable commercial impression.

Conclusion. Applicant's mark is clearly distinct from the cited marks. Applicant respectfully submits that it is highly unlikely that potential consumers of Applicant's or Registrants' services would be confused as to the source of the respective services.

REMARKS

Applicant believes it has responded satisfactorily to the Examining Attorney's objections, and has demonstrated that no likelihood of confusion exists between its mark and the cited marks. For the foregoing reasons, Applicant respectfully requests that the Examining Attorney reconsider this application and allow it to proceed to publication. If the Examining Attorney does not reconsider her decision, then this Application should proceed to Appeal, where it is requested that the Appeal be suspending pending the disposition of the concurrently filed Petition for Cancellation of Registration Nos.: 1986652 and 1808113.

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DESCRIPTION OF EVIDENCE FILE	ROA EMDRIA, Wikipedia entry, Registrant's website reference list with links, Aetna Clinical EMDR Program approval, US Dept. of Veteren's Affairs EMDR adoption, list of government and professional EMDR treatment adoption for PTS disorders, third party clinicians using EMDR techniques, EMDR clinician listings, EMDR definitions, EMDR books, EMDR manuals, EMDRIA TESS entry of disclaimer, EMDRIA International website references to techniques, EMDR articles concerning treatment and skeptics, Trauma Institute EMDR training program, EMDR technology software product, EMDR clinical studies, EMDR white paper has been attached.
SIGNATURE SECTION	
RESPONSE SIGNATURE	/trw/
SIGNATORY'S NAME	Tawnya Wojciechowski
SIGNATORY'S POSITION	Attorney of Record, California bar member
DATE SIGNED	03/01/2011
AUTHORIZED SIGNATORY	YES
CONCURRENT APPEAL NOTICE FILED	NO

FILING INFORMATION SECTION	
SUBMIT DATE	Tue Mar 01 16:46:26 EST 2011
TEAS STAMP	USPTO/RFR-98.189.11.166-2 01103011646265597 72-77857 591-480e5f0684e5a5fcde148 15b2eaef0d627-N/A-N/A-201 10301163012971374

PTO Form (Rev 4/2000)
OMB No. 0651-.... (Exp. 08/31/2004)

Request for Reconsideration after Final Action

To the Commissioner for Trademarks:

Application serial no. **77857591** has been amended as follows:

ARGUMENT(S)
In response to the substantive refusal(s), please note the following:

IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

In the Application of Sierra Tucson, Inc.

Serial Number: 77857591

Mark: **EMDR INTENSIVES**

International Class: 44

Examining Attorney: Nakia D. Henry

Law Office: 111

Commissioner for Trademarks

P O Box 1451

Alexandria, VA 22313-1451

REQUEST FOR RECONSIDERATION

AND NOTICE OF APPEAL

Applicant submits the following remarks and evidence in response to the Office Action electronically transmitted September 1, 2011.

DISCLAIMER

The Examining Attorney accepted Applicant's disclaimer of the term EMDR, thus agreeing that the term EMDR is at the least merely descriptive, and more appropriately, a generic acronym for the phrase "Eye Movement Desensitization and Reprocessing" as a Attached hereto are numerous references to the EMDR technique, used by many multiple parties unrelated to the cited Registrant. (See Wikipedia entry, Aetna clinical advisory, government and professional adoption of use of EMDR techniques, unrelated third party clinicians) As such, no single entity or person can claim any exclusive right to use the term EMDR.

NOTICE OF APPEAL AND REQUEST FOR SUSPENSION PENDING CANCELLATION PROCEEDING

AGAINST REGISTRATION NO.: 1986652 and 1808113.

Applicant has concurrently filed an appeal of the Examining Attorney's decision, and if this request for reconsideration is not traversed, then Applicant requests suspension of the appeal pending the outcome of its concurrently filed Petition for Cancellatiom

LIKELIHOOD OF CONFUSION

The Examining Attorney has refused registration of Applicant's mark, **EMDR INTENSIVES** (shown below) under Trademark Action Section 2(d), 15 U.S.C. Section 1052(d), stating that Applicant's mark, when used on or in connection with the identified goods, so resembles the marks in U.S. Registration Nos. 3369419, and 2117226, 1986652 and 1808113 as to be likely to cause confusion, to cause mistake, or to deceive.

Applicant respectfully disagrees with the Examining Attorney as to a likelihood of confusion between its mark and the cited marks. Applicant asserts that there is sufficient difference between its mark and the cited marks so that confusion is not likely. As such refusal relates to Registration No.: 3369419 for EMDRIA EDMR INTERNATIONAL ASSOCIATION (and stylized Design), the Registration has specifically disclaimed any exclusive right to use the term EMDR, and as such, such registration cannot form the basis of rejection by the Examining Attorney. Applicant has applied to register its mark EDMR INTENSIVES for the services, "psychological assessment services, psychological consultation, psychological counseling, psychological testing and psychological tests," in International class 44. Cited Registration No. 3369419 is for the mark EMDRIA EMDR International Association and Design for "association services, namely promoting the interests of clinical and research psychologists". In its application to register the association services mark, the Registrant went to great lengths to distance itself from the offering of psychological services and instead, differentiated its services as an international association for practitioners utilizing the disclaimed EMDR therapy. (See file history response to official action) Applicant's mark is different when visually and orally compared in their entireties. The examining attorney cannot arbitrarily dissect the marks and compare the marks specifically, the disclaimed portion of the marks) to find that the marks are confusingly similar. Registrant's mark EMDRIA EMDR

INTERNATIONAL ASSOCIATION (along with graphical elements) and Applicant's mark is EMDR INTENSIVES. The marks are completely different, pronounced different and but for the disclaimed portion, would have no similarity whatsoever. Applicant requests reconsideration of this registration as a basis for rejection. The remaining marks are owned by EMDR Institute, Inc. and are the subject of a concurrently filed petition for cancellation by Applicant.

Registration No. 2117226 is for the mark EMDR INSTITUTE, INC. for "educational services, namely seminars, workshops, classes and training in the field of psychology and psychotherapy" and psychological testing and consultation services and psychotherapy services; and cited Registration No. 1986652 is for the mark EMDR for "educational services in the field of psychological testing and consultation services and psychotherapy services and educational services in the field of psychology and psychotherapy" and last, Registration No.: 1808113 is for "educational services for professionals in the field of mental health." Each of the cited registrations are owned (or consented to) by the person who developed the EMDR technique, Ms. Francine Shapiro. However, she has used and continues to use this descriptive acronym to describe the actual technique used in conjunction with mental health therapy, or Eye Movement Desensitization and Reprocessing. This technique is widely referenced by its descriptive acronym in the mental health industry, and is used generically to reference such technique. See all attached third party usage. No single entity or person can effectively claim the exclusive right to use this admittedly generic phrase, nor the acronym widely used to reference the descriptive phrase, something the examiner has recognized by her requirement that the phrase and acronym be disclaimed. While Ms. Shapiro may have invented the technique, its generic usage in the phsychological testing industry and lack of singular ownership means that Applicant likewise has no right to claim any exclusive right to the acronym EMDR. The mark EMDR merely identifies a process or system; it does not function as a service mark to identify and distinguish Registrant's services from those of others and to indicate the source of Registrant's services. Trademark Act Sections 1, 2, 3 and 45, 15 U.S.C. §§1051-1053, 1127; *see In re Universal Oil Prods. Co.*, 476 F.2d 653, 655-56, 177 USPQ 456, 457 (C.C.P.A. 1973) (holding the wording PACOL as used on the specimen is the name of a direct catalytic dehydrogenation process and does not identify the services in the application, "research, development, evaluation, market and economic studies, consultation, design, engineering, and technical services," in connection with the identified process; the wording PENEX as used on the specimen is the name of a continuous catalytic isomerization process and also does not identify similar services in the application); TMEP §§904.07(b), 1301.02(e). A process or system is a way of doing something, and is not generally a service. Thus the name of a system or process does not function as a service mark unless it is also used to indicate the exclusive source of the services. *In re Hughes Aircraft Co.*, 222 USPQ 263, 264 (TTAB 1984); TMEP §1301.02(e). Determining whether matter functions solely as the name of a system or process and also as a service mark is based on the manner in which the mark is used in commerce. *In re Hughes Aircraft*, 222 USPQ at 264; TMEP§1301.02(e). In this case, the plethora of evidence shows the applied-for mark used solely to identify a process or system because wherever EDMR is used, it identifies a psychological technique or method. For example, the Registrant's website includes a statement specifically stating that it has no affiliation with various groups utilizing the name EMDR in its reference list, namely: "These organizations are not affiliated with the EMDR Institute or Francine Shapiro, PhD." The term EMDR is now recognized all over the world as a very effective technique using Eye Movement Desensitizing and Reprocessing (with some clinical reservations, as noted on in several of the attached articles) for treating post-traumatic stress. Registrant itself recognizes the generic usage of the acronym for trauma treatment, and not just trauma treatment associated with Registrant's services. Registrant states " Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories

(Shapiro, 1989a, 1989b)."

In fact, the prior Registrant has a distinctiveness limitation statement for Registration No.: 2117226 specifically limiting the acronym EMDR. As such, and in view of such widespread industry use of the acronym EMDR in a generic mannerfor a specific mental health technique, Applicant respectfully submits that the Examining Attorney has improperly dissected its mark. Applicant's mark consists of the clearly descriptive letters EMDR combined with the word INTENSIVES. Applicant respectfully maintains that the similarity of the marks, if any, is minimal. First, Applicant respectfully submits that the literal element of its mark is not just the generic acronym EMDR but rather, "EMDR INTENSIVES." Applicant contends that the differences in the marks far outweighs any point of similarity. Several marks that had common or similar elements have avoided a finding of likelihood of confusion. See, e.g., *Mr. Hero Sandwich Systems, Inc. v. Roman Meal Co.*, 228 USPQ 364 (CA FC 1986) (ROMAN and ROMANBURGER were not confusingly similar), and *Bell Laboratories, Inc. v. Colonial Products, Inc.*, 231 USPQ 569 (DC S Fla 1986) (FINAL FLIP and FINAL, for pesticides, were not confusingly similar). Applicant's mark creates a distinguishable appearance from the cited marks, and when properly compared in their entireties, Applicant's mark gives a distinct and distinguishable commercial impression.

Conclusion. Applicant's mark is clearly distinct from the cited marks. Applicant respectfully submits that it is highly unlikely that potential consumers of Applicant's or Registrants' services would be confused as to the source of the respective services.

REMARKS

Applicant believes it has responded satisfactorily to the Examining Attorney's objections, and has demonstrated that no likelihood of confusion exists between its mark and the cited marks. For the foregoing reasons, Applicant respectfully requests that the Examining Attorney reconsider this application and allow it to proceed to publication. If the Examining Attorney does not reconsider her decision, then this Application should proceed to Appeal, where it is requested that the Appeal be suspending pending the disposition of the concurrently filed Petition for Cancellation of Registration Nos.: 1986652 and 1808113.

EVIDENCE

Evidence in the nature of ROA EMDRIA, Wikipedia entry, Registrant's website reference list with links, Aetna Clinical EMDR Program approval, US Dept. of Veteren's Affairs EMDR adoption, list of government and professional EMDR treatment adoption for PTS disorders, third party clinicians using EMDR techniques, EMDR clinician listings, EMDR definitions, EMDR books, EMDR manuals, EMDRIA TESS entry of disclaimer, EMDRIA International website references to techniques, EMDR articles concerning treatment and skeptics, Trauma Institute EMDR training program, EMDR technology software product, EMDR clinical studies, EMDR white paper has been attached. has been attached.
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Converted PDF file(s) (3 pages)
Evidence-1
Evidence-2

Evidence-3
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Converted PDF file(s) (2 pages)
Evidence-1
Evidence-2
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Evidence-6
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evi_9818911166-163012971_._Treating_Child_Abuse_with_EMDR.pdf
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SIGNATURE(S)
Request for Reconsideration Signature
Signature: /trw/ Date: 03/01/2011
Signatory's Name: Tawnya Wojciechowski
Signatory's Position: Attorney of Record, California bar member

The signatory has confirmed that he/she is an attorney who is a member in good standing of the bar of the highest court of a U.S. state, which includes the District of Columbia, Puerto Rico, and other federal territories and possessions; and he/she is currently the applicant's attorney or an associate thereof; and to the best of his/her knowledge, if prior to his/her appointment another U.S. attorney or a Canadian attorney/agent not currently associated with his/her company/firm previously represented the applicant in this matter: (1) the applicant has filed or is concurrently filing a signed revocation of or substitute power of attorney with the USPTO; (2) the USPTO has granted the request of the prior representative to withdraw; (3) the applicant has filed a power of attorney appointing him/her in this matter; or (4) the applicant's appointed U.S. attorney or Canadian attorney/agent has filed a power of attorney appointing him/her as an associate attorney in this matter.

The applicant is not filing a Notice of Appeal in conjunction with this Request for Reconsideration.

Serial Number: 77857591
Internet Transmission Date: Tue Mar 01 16:46:26 EST 2011
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aef0d627-N/A-N/A-20110301163012971374

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General Adult Psychiatry

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Website: www.pshrink.com

About EMDR

updated 1999/10/14

EMDR stands for Eye Movement Desensitization and Reprocessing. It was discovered by Francine Shapiro, Ph.D., in 1987. We're not sure why it works, but it does. Simply by providing side-to-side sensations to a person while discussing traumatic events in a specific therapeutic fashion can work wonders in allowing the person to heal himself or herself.

You don't even need eye movements. Dr. Shapiro now simply calls it Reprocessing Therapy. A way to let the mind's own natural healing processes get unblocked and go to work. Sounds too good to be true, but it does work.

And one thing to remember: EMDR is an approach to therapy, not just a technique or a gimmick. Proper training is absolutely required.

Interested? Visit the EMDR website. I was interested enough to learn about it, and convinced enough that I can help my patients with it that I spent my own money to get both levels of training in EMDR.

When a patient and a therapist do EMDR, the therapist asks the patient to bring to mind the incident the patient wants to work on, the negative thinking caused by the incident, and the new thoughts the patient wants to have. Then the therapist moves her or his fingers rapidly back and forth in front of the patient. The patient follows the fingers with his or her eyes. After a number of sets of movements, patients generally think and feel quite differently about the incident, similar incidents, and themselves. Healing has started.

As I noted above, you don't need eye movements. Taps to hands, right and left, sounds alternating ear-to-ear, and even alternating movements by the patient can work instead. The key seems to be the alternating

stimulation of the two sides of the brain.

Now, I have a couple of theories as to how and why EMDR might work. Dr. Shapiro postulates networks of memories and cognitions; negative ones surrounding the unprocessed hurts and positive ones surrounding the state of acceptance and wisdom we would like to achieve. EMDR, she believes (and I agree with her) links the two, so that the insight we have in our heads can heal the hurt in our heart. So, how does this occur?

First of all, consider work done on the different ways that the two halves of our brains look at the world: the left side of the brain (controlling the right side of our bodies) is more positive in outlook, more analytical, looking ahead. Call it your pilot personality.

The right side of the brain tends to a more morose outlook, more holistic, scanning the world for threats. Call it your tail gunner. I suspect that the alternate-side stimulation occurring in EMDR might be simultaneously stimulating positive networks in the left brain while invoking negative networks in the right brain.

Those who know some EMDR might ask how that could be true, since vertical movements help patients in addition to the normal side-to-side movements. I suspect that no one starts with vertical movements; we all start with side-to-side movements. Perhaps that initial movement stays with the patient. In any case, vertical movements are not as effective as side-to-side movements in promoting healing. they are used more for relaxation.

Let us next consider the function of dreams: all but the most primitive mammals dream. The few that don't are small and have huge frontal lobes.

It looks like we need to dream to go over the events of our lives, extract guidance for the future, and throw away mere detail. This is why we can get away with frontal lobes that are not a foot across.

Normal memory is literally re-membered: it is re-assembled from stored clues or instructions which rely on contextual cues to fill in details. A traumatic "memory", however, is stored very differently. Better to call it a "reverie", because all the sights and sounds and sensations of the original moment are stored as if freshly experienced (many of us suspect that is because they are constantly re-experienced).

When we dream, we have the opportunity to put the reverie into perspective, let it go, and store only the instructions for normal memory. On the other hand, when a reverie is too intense, the sleeper wakes, and the dream remains unfinished. No perspective. No putting-away. No memory, just continuing reveries.

While we dream, our eyes move (in what are called Rapid Eye Movements, or REMs). I suspect this may be due to alternating influences from the right and left halves of the brain. Even if that is not what happens, the eyes still move.

EMDR may come close enough to imitating those eye movements that the work of dreams can be done while the patient is awake. Since the patient is already awake, the dream does not have to end. It can continue while the patient holds onto the her-and-now, and the work of the dream may be finished. Memory is left where once there was only reverie.

Now the sleeper may sleep, and not be frightened from sleep by horrid nightmares. Healing has happened.

Just a theory, you understand.

To Dr. Hume's home page

What does EMDR stand for?

Eye Movement Desensitization and Reprocessing

This definition appears very rarely and is found in the following Acronym Finder categories:

- Science, medicine, engineering, etc.

Other Resources:

Search our Acronym Attic for EMDR

<< Previous **Abbreviation Database Surfer** **Next >>**

Endoscopic Microsurgical Dissection of the Oesophagus
Expeditionary Medical Operations Squadron (US DoD)
Electrical Motor-Driven Pump
Engine Model Derivative Program
Enhanced MDSL Data Pump
Executive & Management Development Program
Exercise Movement and Dance Partnership
Extended Medical Degree Programme (King's College University London; UK)
Emergency Medical Dispatch Priority Reference System
Ethiopian Movement for Democracy Peace and Unity
Eastern and Mountain District Radio Club (Australia)
Eye Movement Desensitization and Reprocessing International Association
Ecosystem Management Decision Support (software)
Electrical Munitions Disposal System
Electromagnetic Design System (Agilent)
Emergency Data System
Enhanced Mass Data Storage
Enterprise Mobile Data Security
Ethiopian Mineral Development Share Company (Addis Ababa, Ethiopia)
Eastern Missouri Dark Sky Observers

Samples in periodicals archive:

50 Paperback RC489 Maiberger, an EMDRIA-approved consultant and therapist, provides an overview of Eye Movement Desensitization and Reprocessing (EMDR) therapy that shows how this approach can be used for the treatment of eating disorders, phobia, anxiety and the effects of sexual abuse.

EMDR essentials: a guide for clients and therapists
EMDR Eye Movement Desensitization and Reprocessing.

Got Eye-Floaters?
Eye Movement Desensitization and Reprocessing (EMDR) works even better when EFT is infused.

Combining EFT with Other Healing Processes
Psychotherapy Interventions The psychotherapeutic interventions with the strongest scientific support are trauma-focused CBT, which comprises varying combinations of exposure therapy and trauma-focused cognitive therapy, nontrauma-focused therapy, and eye movement desensitization and reprocessing (EMDR).

Posttraumatic stress disorder and posttraumatic stress disorder-like ...
Eye Movement Desensitization and Reprocessing Eye movement desensitization and reprocessing (EMDR).

Effective practices for sexually traumatized girls: implications for ...
DAVIDSON, PR & PARKER, KCH 2001: Eye movement desensitization and reprocessing (EMDR): A meta-analysis.

Treating phobias or treating people? Of acronyms and the social ...
cognitive behavioral therapy) and eye movement desensitization and reprocessing (EMDR) are recommended for those with severe post-traumatic symptoms or PTSD; for those at risk of developing PTSD, there should be routine use of a brief screening instrument.

The United Kingdom: practical support and expert assessment
Research suggests that behavioral therapies effective with anxiety disorders include systematic desensitization, exposure, stress inoculation, eye movement desensitization and reprocessing (EMDR), and relaxation training (Kennedy, 2002).

The common factors, empirically validated treatments, and recovery ...

Aetna

Clinical Policy Bulletin: Eye Movement Desensitization and Reprocessing (EMDR) Therapy

Policy History

> Last Review: 01/07/2011
Effective: 11/16/2001
Next Review: 07/28/2011
> Review History
> Definitions

Additional Information

> Clinical Policy Bulletin Notes

Number: 0583

Policy

I. Aetna considers eye movement desensitization and reprocessing (EMDR) therapy medically necessary for the treatment of post-traumatic stress disorder (PTSD).

II. Aetna considers EMDR therapy experimental and investigational for the following indications because its effectiveness for these indications has not been established (not an all inclusive list):

- prevention of PTSD
- treatment of chronic phantom limb pain
- treatment of panic and anxiety disorders (other than PTSD)
- treatment of other psychiatric and behavioral disorders (e.g., anger, depression, dissociative disoders, eating disorders, guilt, and phobias).

Background

Eye movement desensitization and reprocessing (EMDR) therapy is a complex method of psychotherapy that combines a range of therapeutic approaches with eye movements or other forms of rhythmical stimulation (e.g., sound and touch) in ways that stimulate the brain's information processing system. Eye movement desensitization and reprocessing was introduced in 1989 as a treatment for post-traumatic stress disorder (PTSD). Since then, it has been proposed as a treatment of various psychiatric and behavioral disorders including phobias, panic and anxiety disorders, as well as eating disorders.

Guidelines on PTSD from the National Institute for Clinical Excellence (NICE, 2005) state that all people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioral therapy (CBT) or EMDR). NICE guidelines note that these treatments should normally be provided on an individual outpatient basis.

Guidelines on PTSD from the American Psychiatric Association (APA, 2004) stated that CBT and EMDR have been shown to be effective for core symptoms of acute and chronic PTSD. These guidelines note, however, that no controlled studies of EMDR have been conducted

that would establish data-based evidence of its efficacy as an early preventive intervention for PTSD. APA guidelines state that stress inoculation, imagery rehearsal, and prolonged exposure techniques may also be indicated for treatment of PTSD and PTSD-associated symptoms such as anxiety and avoidance. APA guidelines observe that the shared element of controlled exposure of some kind may be the critical intervention.

In reviewing the evidence supporting EMDR, the APA found that, like many of the studies of other cognitive behavior and exposure therapies, most of the well-designed EMDR studies have been small, but several meta-analyses have demonstrated efficacy similar to that of other forms of cognitive and behavior therapy. The AAP noted that studies also suggest that the "eye movements are neither necessary nor sufficient to the outcome, but these findings remain controversial." "Although it appears that efficacy may be related to the components of the technique common to other exposure- based cognitive therapies, as in the previously described cognitive behavior therapies, further study is necessary to clearly identify the effective subcomponents of combined techniques. Follow-up studies are also needed to determine whether observed improvements are maintained over time" (APA, 2004).

Advocates of EMDR therapy state that it is a specialized approach and method that requires supervised training for full therapeutic effectiveness and client safety. Training is considered mandatory for appropriate use. However, a meta-analysis of the literature on EMDR by Davidson & Parker (2001) found that the effectiveness of EMDR was not affected by whether the therapist providing the treatment was trained by the EMDR Institute.

There is insufficient data to support the use of EMDR in the treatment of other psychiatric and behavioral disorders including anger, guilt, phobias, dissociative disorders, eating disorders, and panic and anxiety disorders other than PTSD. In a randomized study on the effectiveness of EMDR treatment on negative body image in eating disorder inpatients, Bloomgarden and Calogero (2008) conclued that further research is needed to determine whether or not EMDR is effective for treating the variety of eating pathology presented by eating disorder inpatients.

In a case series, Schneider et al (2008) assessed EMDR therapy for patients with chronic phantom limb pain. A total of 5 subjects with phantom limb pain ranging from 1 to 16 years were included in this study. All patients were on extensive medication regimens prior to EMDR therapy. Three to 15 sessions of EMDR were used to treat the pain and the psychological ramifications. Patients were measured for continued use of medications, pain intensity/frequency, psychological trauma, and depression. Treatment with EMDR resulted in a significant decrease or elimination of phantom pain, reduction in depression and PTSD symptoms to sub-clinical levels, and significant reduction or elimination of medications related to the phantom pain and nociceptive pain at long-term follow-up. The authors concluded that the overview and long-term follow-up indicate that EMDR therapy was successful in the treatment of both the phantom limb pain and the psychological consequences of amputation. The latter include issues of personal loss, grief, self-image, and social adjustment. These results suggest that (i) a significant aspect of phantom limb pain is the physiological memory storage of the nociceptive pain sensations experienced at the time of the event, and (ii) these memories can be successfully reprocessed. They stated that further research is needed to explore the theoretical and treatment implications of this information-processing approach.

In a pilot study, Sandström and colleagues (2008) examined the effects of EMDR in women with post-traumatic stress after childbirth. This study consisted of a "before and after" treatment design combined with follow-up measurements 1 to 3 years after EMDR treatment. Quantitative data from questionnaires (Traumatic Event Scale [TES]) were collected. In addition, qualitative data from individual interviews with the participants were collected as well

as data from the psychotherapist's treatment notes of the EMDR treatment sessions. A total of 4 women with post-traumatic stress following childbirth (1 pregnant and 3 non-pregnant) were included in this study. All participants reported reduction of post-traumatic stress after treatment. After 1 to 3 years, the beneficial effects of EMDR treatment remained for 3 of the 4 women. Symptoms of intrusive thoughts and avoidance seemed most sensitive for treatment. The authors concluded that EMDR might be a useful tool in the treatment of non-pregnant women severely traumatized by childbirth; however, they stated that further research is needed.

Bae et al (2008) stated that while CBT is considered to be the first-line therapy for adolescent depression, there are limited data on whether other psychotherapeutic techniques are also effective in treating adolescents with depression. This report suggested the potential application of EMDR for treatment of depressive disorder related, not to trauma, but to stressful life events. At present, EMDR has only been empirically validated for only trauma-related disorders such as PTSD. These researchers reported the findings of 2 teenagers with major depressive disorder (MDD) who underwent 3 and 7 sessions of EMDR aimed at memories of stressful life events. After treatment, their depressive symptoms decreased to the level of full remission, and the therapeutic gains were maintained after 2 and 3 months of follow up. The effectiveness of EMDR for depression is explained by the model of adaptive information processing. Given the powerful effects observed within a brief period of time, the authors suggested that further investigation of EMDR for depressive disorders is warranted.

CPT Codes / HCPCS Codes / ICD-9 Codes

There is no specific CPT code for eye movement desensitization and reprocessing:

Other CPT codes related to the CPB:

90823 - 90899

ICD-9 codes covered if selection criteria are met:

309.81	Posttraumatic stress disorder
V11.4	Personal history of combat and operational stress reaction

ICD-9 codes not covered for indications listed in the CPB:

290.0 - 309.4, 309.82 - 319	Mental disorders (other than posttraumatic stress disorder)
353.6	Phantom limb (syndrome)

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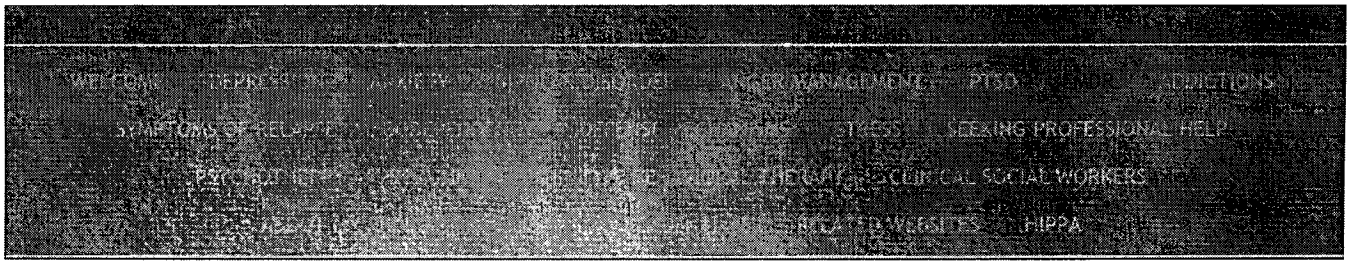
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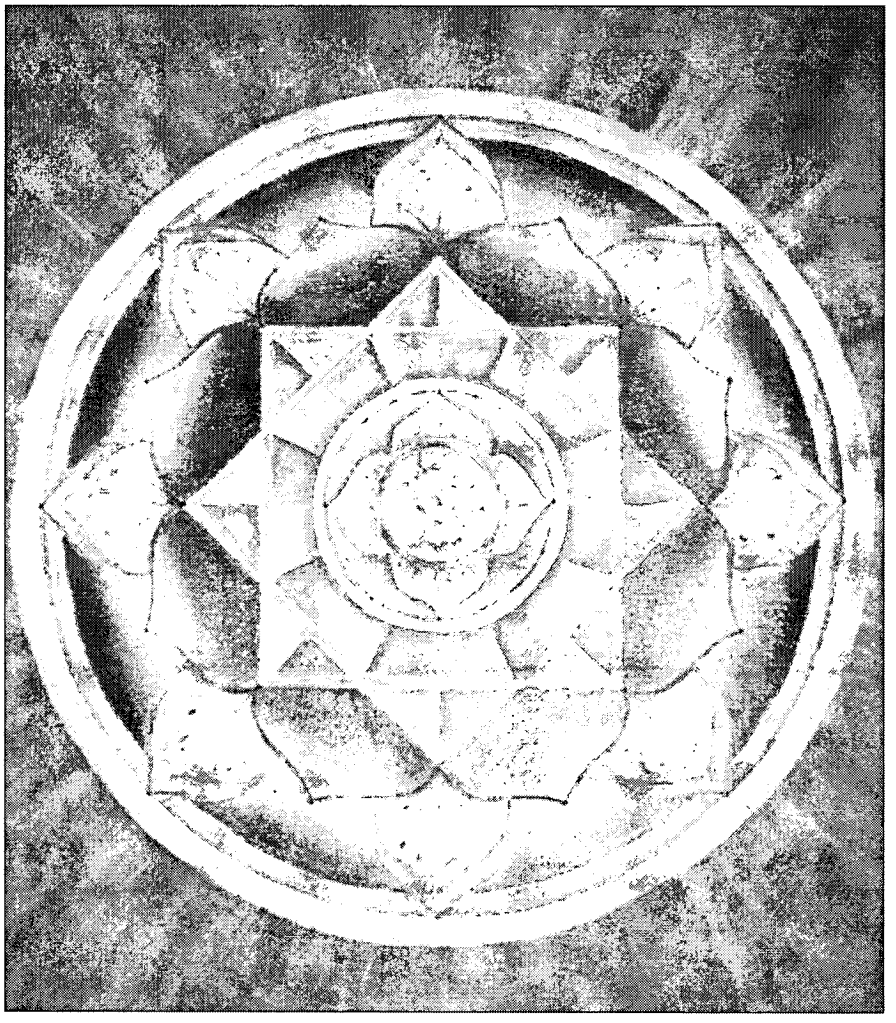
EMDR Therapy Spotlight

Don't just talk about your problems, 'EMDR' something about them!



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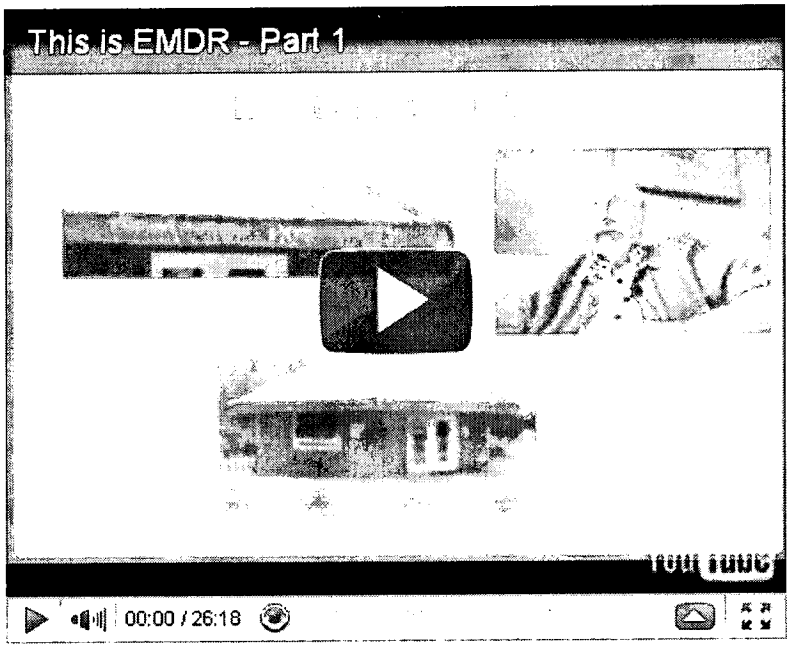

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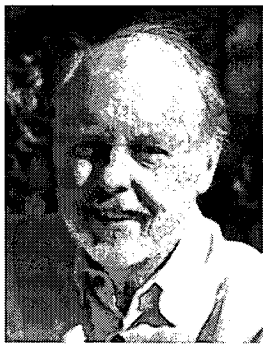

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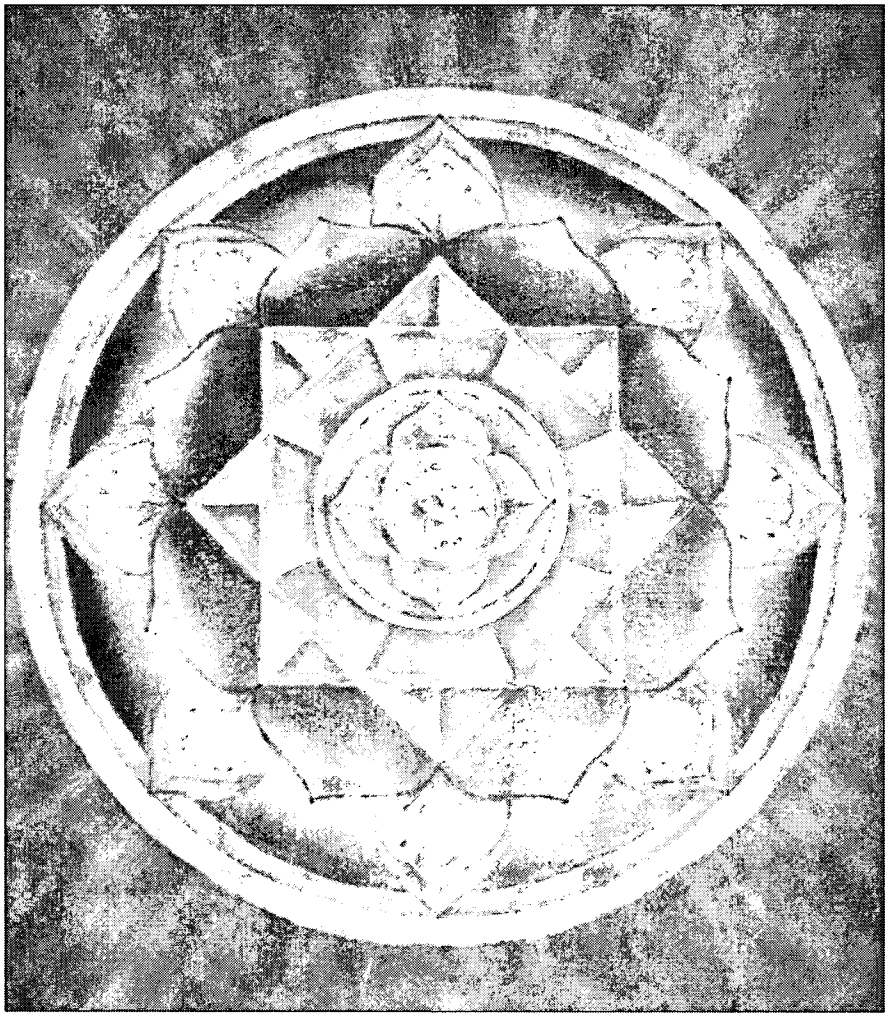

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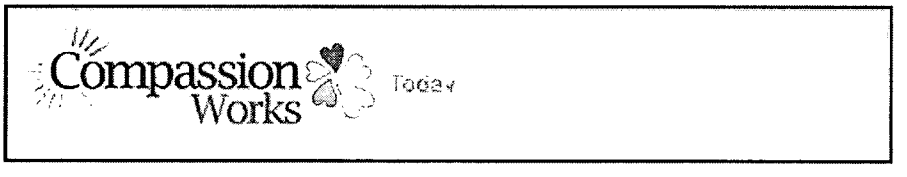

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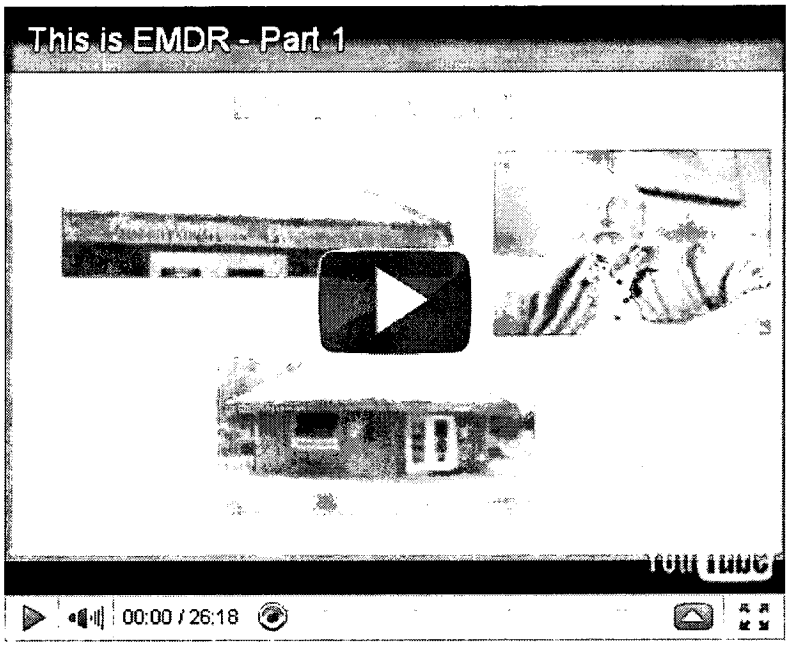

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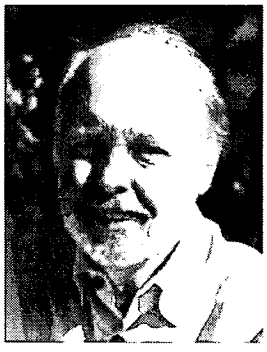

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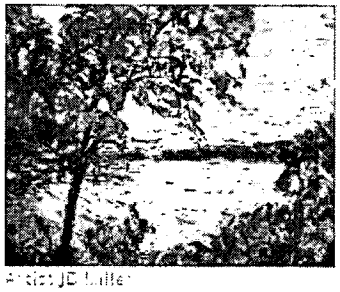

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Creating Healthy Connections
Carol Corcoran, LCMFT, LMFT

Creating healthy connections . . . connections within. . . and with those

Home | Couples Therapy | Family Therapy | Trauma / PTSD | EMDR | Individual Therapy | Child Therapy | Graduate CHC

ABOUT CHC | EXPERIENCE | EDUCATION

Welcome to the website devoted to Creating Healthy Connections.

Do you find yourself in relationships where you struggle with unhealthy connections? Connections where you may experience some signs of depression, anxiety, stress, or emotional trauma, leaving you feeling physically drained. Or do you at times find yourself medicating with addictive substances, shopping, technology, or other unhealthy options? Are there times when you find yourself struggling with unhealthy relationship problems with others, or do you experience deep unhealthy connections within yourself that leave you feeling overwhelmed, confused, helpless, hopeless or lonely?

Here are some areas where you may be challenged by unhealthy connections and options for treatment:

- ***Couples Counseling for Relationship Problems***
- ***Marriage Counseling for Marriage Problems***
- ***EMDR Therapy for Trauma/PTSD/Depression***
- ***Family Counseling for Family Problems***
- ***Child Counseling for Child Problems***
- ***Individual Therapy for Improved Mental Health***

If any of this is true for you, I can help.

My name is Carol Corcoran, LCMFT, LMFT, and I am a highly skilled Licensed Clinical Marriage & Family Therapist who can assist you in the process of creating more healthy connections within yourself or with those that matter most.

- Experience
- Education
- Contact

I provide a safe, supportive, connective space in which we are able to explore your feelings, thoughts, and experiences in a way that will help you and those closest to you move towards a more connective way of being.

To learn more continue on, or to make an appointment please call 443-254-0686
or send and email to Carol Corcoran, LCMFT, LMFT at: chc@creatinghealthyconnections.com
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UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

NATIONAL CENTER FOR PTSD

Treatment of PTSD

Related Handout (PDF)
Treatment of PTSD (PDF)

Today, there are good treatments available for PTSD. When you have PTSD, dealing with the past can be hard. Instead of telling others how you feel, you may keep your feelings bottled up. But talking with a therapist can help you get better.

Cognitive behavioral therapy (CBT) is one type of counseling. It appears to be the most effective type of counseling for PTSD. The VA is providing two forms of cognitive behavioral therapy to Veterans with PTSD: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) therapy. To learn more about these types of therapy, see our fact sheets listed on the Treatment page.

There is also a similar kind of therapy called eye movement desensitization and reprocessing (EMDR) that is used for PTSD. Medications have also been shown to be effective. A type of drug known as a selective serotonin reuptake inhibitor (SSRI), which is also used for depression, is effective for PTSD.

Types of cognitive behavioral therapy

What is cognitive therapy?

In cognitive therapy, your therapist helps you understand and change how you think about your trauma and its aftermath. Your goal is to understand how certain thoughts about your trauma cause you stress and make your symptoms worse.

You will learn to identify thoughts about the world and yourself that are making you feel afraid or upset. With the help of your therapist, you will learn to replace these thoughts with more accurate and less distressing thoughts. You will also learn ways to cope with feelings such as anger, guilt, and fear.

After a traumatic event, you might blame yourself for things you couldn't have changed. For example, a soldier may feel guilty about decisions he or she had to make during war. Cognitive therapy, a type of CBT, helps you understand that the traumatic event you lived through was not your fault.

What is exposure therapy?

In exposure therapy your goal is to have less fear about your memories. It is based on the idea that people learn to fear thoughts, feelings, and situations that remind them of a past traumatic event.

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Where to Get Help for PTSD

Are you looking for someone to help you or a family member?

By talking about your trauma repeatedly with a therapist, you'll learn to get control of your thoughts and feelings about the trauma. You'll learn that you do not have to be afraid of your memories. This may be hard at first. It might seem strange to think about stressful things on purpose. But you'll feel less overwhelmed over time.

With the help of your therapist, you can change how you react to the stressful memories. Talking in a place where you feel secure makes this easier.

You may focus on memories that are less upsetting before talking about worse ones. This is called "desensitization," and it allows you to deal with bad memories a little bit at a time. Your therapist also may ask you to remember a lot of bad memories at once. This is called "flooding," and it helps you learn not to feel overwhelmed.

You also may practice different ways to relax when you're having a stressful memory. Breathing exercises are sometimes used for this.

What is EMDR?

Eye movement desensitization and reprocessing (EMDR) is another type of therapy for PTSD. Like other kinds of counseling, it can help change how you react to memories of your trauma.

While thinking of or talking about your memories, you'll focus on other stimuli like eye movements, hand taps, and sounds. For example, your therapist will move his or her hand near your face, and you'll follow this movement with your eyes.

Experts are still learning how EMDR works. Studies have shown that it may help you have fewer PTSD symptoms. But research also suggests that the eye movements are not a necessary part of the treatment.

Medication

Selective serotonin reuptake inhibitors (SSRIs) are a type of antidepressant medicine. These can help you feel less sad and worried. They appear to be helpful, and for some people they are very effective. SSRIs include citalopram (Celexa), fluoxetine (such as Prozac), paroxetine (Paxil), and sertraline (Zoloft).

Chemicals in your brain affect the way you feel. For example, when you have depression you may not have enough of a chemical called serotonin. SSRIs raise the level of serotonin in your brain.

There are other medications that have been used with some success. Talk to your doctor about which medications are right for you.

Other types of treatment

Some other kinds of counseling may be helpful in your

recovery. However, more evidence is needed to support these types of treatment for PTSD.

Group therapy

Many people want to talk about their trauma with others who have had similar experiences.

In group therapy, you talk with a group of people who also have been through a trauma and who have PTSD. Sharing your story with others may help you feel more comfortable talking about your trauma. This can help you cope with your symptoms, memories, and other parts of your life.

Group therapy helps you build relationships with others who understand what you've been through. You learn to deal with emotions such as shame, guilt, anger, rage, and fear. Sharing with the group also can help you build self-confidence and trust. You'll learn to focus on your present life, rather than feeling overwhelmed by the past.

Brief psychodynamic psychotherapy

In this type of therapy, you learn ways of dealing with emotional conflicts caused by your trauma. This therapy helps you understand how your past affects the way you feel now.

Your therapist can help you:

- Identify what triggers your stressful memories and other symptoms.
- Find ways to cope with intense feelings about the past.
- Become more aware of your thoughts and feelings, so you can change your reactions to them.
- Raise your self-esteem.

Family therapy

PTSD can affect your whole family. Your kids or your partner may not understand why you get angry sometimes, or why you're under so much stress. They may feel scared, guilty, or even angry about your condition.

Family therapy is a type of counseling that involves your whole family. A therapist helps you and your family to communicate, maintain good relationships, and cope with tough emotions. Your family can learn more about PTSD and how it is treated.

In family therapy, each person can express his or her fears and concerns. It's important to be honest about your feelings and to listen to others. You can talk about your PTSD symptoms and what triggers them. You also can discuss the important parts of your treatment and recovery. By doing this, your family will be better prepared to help you.

You may consider having individual therapy for your PTSD symptoms and family therapy to help you with your relationships.

How long does treatment last?

CBT treatment for PTSD often lasts for 3 to 6 months. Other types of treatment for PTSD can last longer. If you have other mental health problems as well as PTSD, treatment may last for 1 to 2 years or longer.

What if someone has PTSD and another disorder? Is the treatment different?

It is very common to have PTSD at that same time as another mental health problem. Depression, alcohol or drug abuse problems, panic disorder, and other anxiety disorders often occur along with PTSD. In many cases, the PTSD treatments described above will also help with the other disorders. The best treatment results occur when both PTSD and the other problems are treated together rather than one after the other.

What will we work on in therapy?

When you begin therapy, you and your therapist should decide together what goals you hope to reach in therapy. Not every person with PTSD will have the same treatment goals. For instance, not all people with PTSD are focused on reducing their symptoms.

Some people want to learn the best way to live with their symptoms and how to cope with other problems associated with PTSD. Perhaps you want to feel less guilt and sadness. Perhaps you would like to work on improving your relationships at work, or communicating with your friends and family.

Your therapist should help you decide which of these goals seems most important to you, and he or she should discuss with you which goals might take a long time to achieve.

What can I expect from my therapist?

Your therapist should give you a good explanation for the therapy. You should understand why your therapist is choosing a specific treatment for you, how long they expect the therapy to last, and how they will tell if it is working.

The two of you should agree at the beginning that this plan makes sense for you. You should also agree on what you will do if it does not seem to be working. If you have any questions about the treatment, your therapist should be able to answer them.

You should feel comfortable with your therapist and feel you are working as a team to tackle your problems. It can be difficult to talk about painful situations in your life, or about traumatic experiences that you have had. Feelings that emerge during therapy can be scary and challenging. Talking with your therapist about the process of therapy, and about your hopes and fears in regards to therapy, will help make therapy successful.

If you do not like your therapist or feel that the therapist is not helping you, it might be helpful to talk with another professional. In most cases, you should tell your therapist that you are seeking a second opinion.

Date Created: 01/01/2007 See last Reviewed/Updated Date below.

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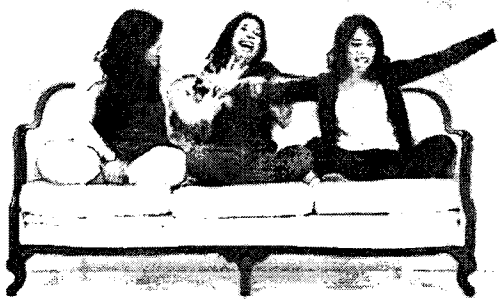

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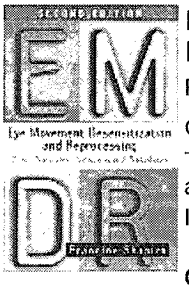

Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures

Francine Shapiro, PhD

Guilford Press, New York, 2001 (2nd ed.)

The primary EMDR textbook essential for mental health professionals and university courses. This book is available through the EMDR Institute and is **required reading.**

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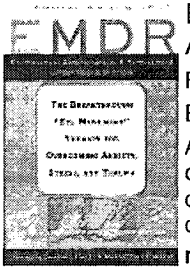

EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma

Francine Shapiro, PhD and Margot Silk Forrest

BasicBooks, New York, 1997

An authoritative introduction for professionals and laypeople and a casebook for trained EMDR clinicians. Chapters cover various types of traumas, phobias, children, addictions, grief, disease, future directions. This book is available through the EMDR Institute and is **required reading**.

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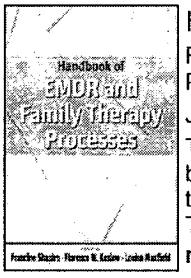

Handbook of EMDR and Family Therapy Processes

Francine Shapiro, PhD, Florence W Kaslow, PhD, & Louise Maxfield, PhD (Editors)

John Wiley & Sons, Inc, New Jersey 2007

This book expands on both individual and systemic treatments, blending theory, practice descriptions,and case examples to illustrate the integrative process with a wide variety of presenting complaints. This book is available through the EMDR Institute and is **required reading**.

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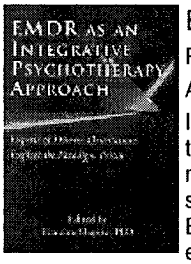

EMDR as an Integrative Psychotherapy Approach

Francine Shapiro, PhD (Editor)

American Psychological Association Books, 2002

Introductory chapters by Dr. Shapiro include case examples and client transcripts to demonstrate EMDR and how the information processing model is used for case conceptualization. Chapters by leading spokespersons of all major schools of psychotherapy describe how EMDR meshes with their approaches and offer specific techniques to enhance the therapeutic process using a wide variety of case illustrations.

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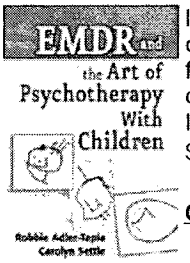
EMDR and The Art of Psychotherapy With Children

Robbie Adler-Tapia, PhD; Carolyn Settle, LCSW

This book focuses on how clinicians can effectively use the entire EMDR protocol and Adaptive Information Processing model with children and adolescents. In addition to articulating how to modify



language and to conceptualize EMDR treatment to meet the age and cognitive ability of the young client, the authors provide a continuum from how to get started using EMDR with children to treating complex cases. Included is a chapter summarizing their research with children. If purchasing this book and the treatment manual, a discounted rate of $72 will be charged for both.

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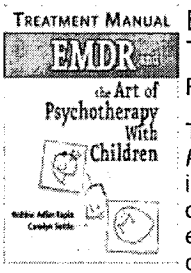

EMDR and The Art of Psychotherapy With Children: Treatment Manual

Robbie Adler-Tapia, PhD; Carolyn Settle, LCSW

This manual, as an adjunct to the book, *EMDR and the Art of Psychotherapy with Children*, provides scripts, forms, and protocols to illustrate the 8 phases of the EMDR model to assist clinicians in organizing and conceptualizing a case. Included are scripts and examples of cognitive interweaves and resource development for children.
If purchasing this book and "EMDR and The Art of Psychotherapy With Children", a discounted rate of $72 will be charged for both.

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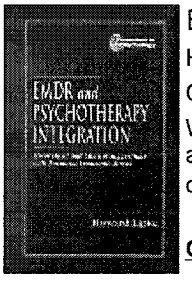

EMDR and Psychotherapy Integration

Howard Lipke, PhD

CRC Press LLC, Florida, 2000

With an emphasis on combat-related psychological problems, the author presents a model that advances the integration of EMDR with other psychotherapy methods and models.

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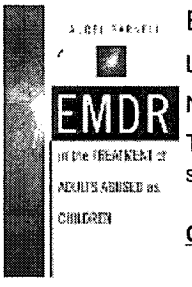

EMDR in the Treatment of Adults Abused as Children

Laurel Parnell, PhD

Norton Professional Books, New York, 1999

This book emphasizes the treatment of complex cases of adult survivors of childhood abuse.

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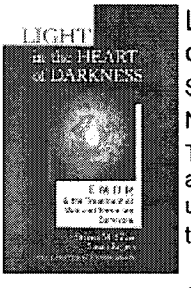

Light in the Heart of Darkness: EMDR and the Treatment of War and Terrorism Survivors

Steve Silver, PhD and Susan Rogers, PhD

Norton Professional Books, New York, 2001

This book includes useful information for all clinicians doing relief work and/or working with cross cultural issues and provides guidelines for using EMDR in the treatment of complex PTSD arising from war and terrorism.

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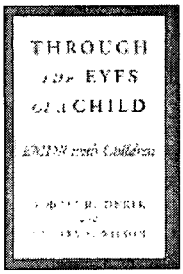
Through The Eyes of a Child

Robert H. Tinker, PhD & Sandra Wilson, PhD

Norton Professional Books, New York, 1999



This book demystifies the application of EMDR for children, from the first session with parents to later sessions with children at all developmental stages. A myriad of cases illustrate the use of EMDR with simple as well as complex traumas. In addition, the authors discuss the use of EMDR as an intervention for children who have problems that are not caused by trauma.

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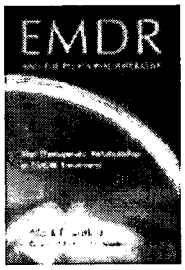

EMDR and the Relational Imperative: The Therapeutic Relationship in EMDR Treatment

Mark Dworkin, CSW-R

Routledge, 2005

This book focuses on how relational issues affect the treatment of traumatized clients, and illustrates these issues through each phase of EMDR treatment. The author gives many suggestions and strategies for how to deal with difficult relational situations and/or problems that may arise between the clinician and client.

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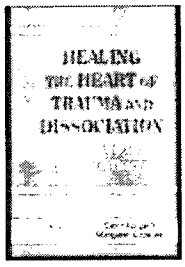

Healing the Heart of Trauma & Dissociation

Carol Forgash, LCSW, & Margaret Copely (Editors)

Springer Publishing, 2008

This book provides a practical approach for the use of EMDR in the comprehensive treatment of complex PTSD (involving dissociation and other challenging diagnoses). The authors stress an integrated approach which combines the 8 phases of EMDR treatment with Ego State Therapy and dissociative disorder treatment strategies. The case examples clearly outline how to extend the EMDR Preparation Phase to create safety and stability necessary for trauma processing.

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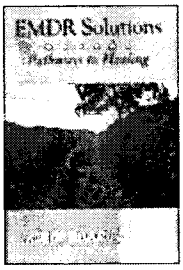

EMDR Solutions: Pathways to Healing

Robin Shapiro, LICSW (Editor)

Norton Professional Books, 2005

EMDR Solutions is a 16 chapter book by a select group of authors, who offer step by step protocols for using EMDR with a variety of populations and clinical issues, including addictions, dissociation, anxiety disorders BPD, couple, children, eating disorders, developmentally challenged clients, and more.

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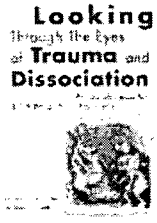

Looking Through The Eyes of Trauma and Dissociation

Sandra Paulson, PhD

Norton Professional Books, 2005

Dr Paulsen uses over 100 of her original cartoons and an approachable format to inform clinicians and clients about the key concepts of dissociation and ego state therapy and how to integrate EMDR into the treatment of complex trauma.

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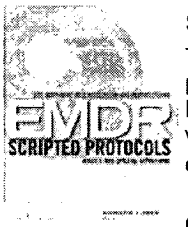
EMDR Scripted Protocols: Basics and Special Situations

Marilyn Luber, PhD



Springer Publishing Company

This book provides a wide range of word-for-word scripted EMDR protocols that are outlined in an easy to use manual style template. Included are past memory, current triggers and future template worksheet scripts plus self-awareness questionnaire to assist clinicians in identifying potential problem areas.

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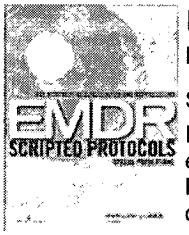

EMDR Scripted Protocols: Special Populations

Marilyn Luber, PhD

Springer Publishing Company

In this book Dr Luber provides scripted protocols applying the basic elements of the EMDR 11 Step Procedure and the standard Three Pronged Protocol to special populations, including: children, couples, complex PTSD, dissociative disorders, addictive behaviors, anxiety and pain.

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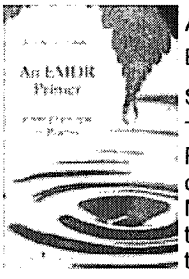

An EMDR Primer

Barbara Hensley, EDD

Springer Publishing Company

This book is intended to be a primer for use as a companion to Dr Francine Shapiro's textbook (See book 1 above). It serves as a comprehensive review of the Adaptive Information Processing (AIP) Model and EMDR principles, protocols and procedures for the newly trained in EMDR and for experienced clinicians who want to review the principles.

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Small Wonders: Healing Childhood Trauma with EMDR

Joan Lovett, MD

The Free Press, New York, 1999

For both parents and therapists, this book elucidates the use of EMDR by a behavioral pediatrician. Careful explanations and detailed case histories illustrate how EMDR may be used for problems as wide-ranging as nightmares, trichotillomania (hair-pulling), phobias, depression, sibling rivalry, grief, and a variety of complaints that can be traced to a child's lack of self-esteem and trust in the world.

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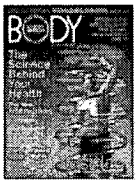

EMDR: Taking a Closer Look

Can moving your eyes back and forth help to ease anxiety?

By Scott O. Lilienfeld and Hal Arkowitz | January 3, 2008 | 15

More than 500 brands of psychotherapy exist, with new ones springing up on a nearly monthly basis. Although a handful of these neophyte treatments have been tested in scientific studies, it is anybody's guess whether the others actually work.

Over the past 15 years or so, one of these new kids on the therapy block has stood out from the pack for the remarkable attention it has received from the media, practitioners and mental health consumers. This treatment carries a mouthful of a label—eye movement desensitization and reprocessing—and it has made an impressive splash on the psychotherapy scene. Not surprisingly, most therapists refer to it simply as " EMDR," and we'll do the same here.

Like some other psychotherapies, EMDR was the brainchild of serendipity. One day in 1987 Francine Shapiro, a California psychologist in private practice, went for a walk in the woods. She had been preoccupied with a host of disturbing thoughts. Yet she discovered that her anxiety lifted after moving her eyes back and forth while observing her surroundings. Intrigued, Shapiro tried out variants of this procedure with her clients and found that they, too, felt better. EMDR was born.

After an initial published study in 1989, EMDR became the focus of dozens of investigations and scores of presentations at professional conferences. Shapiro initially developed EMDR to help clients overcome the anxiety associated with post-traumatic stress disorder (PTSD) and other anxiety disorders, such as phobias. Nevertheless, therapists have since extended this treatment to a host of other conditions, including depression, sexual dysfunction, schizophrenia, eating disorders, and even the psychological stress generated by cancer.

EMDR therapists ask their clients to hold the memories of anxiety-provoking stimuli—for example, the painful memories of a frightening accident—in their minds.

While doing so, clients track the therapist's back-and-forth finger movements with their eyes, much like a person in an old Hollywood movie following a hypnotist's swinging pocket watch. EMDR proponents have invoked a dizzying array of explanations for the apparent effectiveness of the lateral eye movements: distraction, relaxation, synchronization of the brain's two hemispheres, and simulation of the eye movements of rapid eye movement (REM) sleep have all emerged as candidates. In conjunction with their therapists, EMDR clients also learn to replace negative thoughts (such as "I'll never get this job") with more positive thoughts (such as "I can get this job if I try hard enough").

Few psychological treatments have been as widely heralded as EMDR. Some EMDR proponents have called it a "miracle cure" and "paradigm shift," and ABC's 20/20 proclaimed it an "exciting breakthrough" in the treatment of anxiety. More than 60,000 clinicians have undergone formal training in EMDR, and the EMDR International Association (EMDRIA), a group of mental health professionals dedicated to promoting the technique, boasts more than 4,000 members. The organization estimates that this procedure has been administered to approximately two million clients. Moreover, in some American cities, psychotherapists proudly list their certifications in EMDR on their Yellow Pages advertisements. But does it work?

The answer is not entirely straightforward. As with all psychotherapies, one can look at the question of whether EMDR "works" in several different ways. Here we will address three important variants of this question:

Does EMDR work better than doing nothing?

Yes. Numerous controlled studies show that EMDR produces more improvement than absence of treatment, at least for alleviating the symptoms of civilian PTSD, such as those triggered by rape. The evidence that pertains to EMDR's efficacy for other anxiety disorders is promising but preliminary. EMDR's effects are most marked on self-reported measures of anxiety; its impact on physiological measures linked to anxiety (such as heart rate) is less clear-cut.

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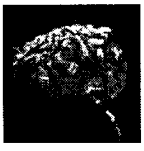

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07:45 PM 1/4/08

Both McNally and Lilienfeld have seemingly taken upon themselves the mission of discrediting EMDR. Ask any therapist who has been trained in EMDR and you will get a completely different opinion. Research psychologists know very little about what works outside of university studies. Clinicians know that EMDR works faster and better than traditional exposure therapies (for PTSD) and that there are much fewer drop-outs.
Dan Opdyke, Ph.D.

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2. cellojazz
09:03 PM 1/4/08

I've received both EMDR and Experiential therapies for anxiety related conditions. Both were effective, each slightly differently than another. As I saw what each did for me, I felt empowered to ask for what I wanted, sometimes EMDR, sometimes Experiential, sometimes both. Why should it be one or the other? Seems like someone was getting defensive - have an issue you'd like to explore? :-)

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3. Zonags
10:09 PM 1/4/08

I am concerned that the same old articles regarding EMDR and its efficacy are being retread as if they were pertaining to new material. There is a failure to look at any relevant data regarding the efficacy of EMDR. There are over 16 controlled studies supporting demonstrating the effectiveness of the 8 phase treatment protocol. In contrast to the claim that there is no difference between EMDR and Exposure Based treatments, the data have indicated that although there was no significant differences in outcome, the EMDR treatment did not require an hour of homework. If one really wants to know whether EMDR works or doesn't work, is different or the same as other treatments, one should be looking at the data and not at reworked statements of the data. Please look at www.emdr.com; www.emdria.org and www.emdr-hap.org for a full depiction of the studies and their results.

Zona Scheiner, Ph.D.

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4. Mark_Wolbrink
11:42 PM 1/4/08

Lilienfeld and McNally attack EMDR as not effective in spite of resounding endorsements of EMDR'S effectiveness in the treatment of trauma. They seem not to notice the world of trauma treatment is moving past them.

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5. liz massiah
07:48 PM 1/5/08

The point is somewhat moot - we don't really know much about what works in psychotherapy - there has been a lot of research on exposure and other cbt therapies - much of it not well done, so to criticize another modalilty onthe basis of old research, seems irrelevant. Comments such as " scientists have,,," are not helpfulor useful and simply contribute to misinformation. This comment seems to be more like pseudo

science than anything else, and since the authors are promoting science, perhaps closer attention is in order.
Liz Massiah

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6. Dr. Patti Levin
04:37 PM 1/7/08

Drs. Lillienfeld and Arkowitz perform an interesting □slight-of-hand□ when they state □no□ to their question, □does EMDR work better than standard behavior [i.e. exposure] and cognitive behavior therapies?□ They do NOT say that EMDR has been found to be of equivalent benefit, leaving the reader possibly assuming that EMDR is a less effective treatment. In fact, several studies have found EMDR equal to or superior in efficiency to CBT (see Van Etten, 1998; Ironson, 2002; Jaberghaderri et al. 2004).
Exposure theorists require specific doses, i.e. continuous stimulation with response prevention, to effect habituation. Thus, EMDR should not make clients better but rather worse, since the intermittent exposure that can occur in EMDR theoretically should tend to increase symptom reactivity rather than dampen it. Accepted habituation/extinction mechanisms of conventional exposure do not seem to explain how EMDR dampens responses without continuous stimulation.
Therefore, while exposure and CBT theorists continuously attempt to subsume EMDR as a kind of exposure therapy, EMDR is far more multi-dimensional.
EMDR is more efficient than CBT or exposure since it does not require homework in between sessions. In fact, when homework was equalized in the Ironson et al. (2002) study, the effectiveness of EMDR was comparable to exposure therapy but more efficient. In three sessions, 70% of the EMDR subjects had significant symptom reduction vs. only 29% of subjects in the exposure cohort. This same efficiency rate was previously noted (three-session remission of 84-90% of PTSD symptoms: Rothbaum, 1997; Wilson et al., 1995, 1997; and 77-100% remission with 5.4 treatment hours Marcus et al., 1997, 2004). Rothbaum et al. (2005) noted: □An interesting potential clinical implication is that EMDR seemed to do equally well in the main despite less exposure and no homework. It will be important for future research to explore these issues.□
Drs. Lillienfeld and Arkowitz state □scant evidence□ that eye movements contribute anything to its effectiveness. However, in seven randomized studies, researchers investigated the eye movements used in EMDR to evaluate several hypotheses, including working memory and the orienting response (see Barrowcliff et. al 2004; Barrowcliff et. al 2003; Christman et. al 2003; Kavanagh et. al 2001; Kuiken et. al 2001-2002; Lee & Drummond in press; and Van den Hout et. al 2001). All seven studies independently corroborate that eye movements have a direct effect upon memory, including distress reduction and diminution of vivid imagery. Psychophysiological research also documents that eye movements create a pronounced parasympathetic activation (e.g., Elofsson et al., in press; Barrowcliff et al., 2003). The ISTSS treatment guidelines

published in 2000 for PTSD indicated that the extant clinical component analyses were flawed and could not be used to determine the role of the eye movement.
While the authors note the large number of EMDR-trained therapists, they do not mention the significant number of randomized clinical trials (over 18) or non-randomized clinical trials (over 8). One might wonder why the authors consistently and energetically publish similar articles attempting to discredit EMDR using misinformation as well as omission of evidence-based research.
Patti Levin, LICSW, PsyD
Boston, MA

Reply | Report Abuse | Link to this

7. richelle sheehan MA, LPC, NCC
07:35 PM 1/7/08

When my 5 year old child and I almost burned to death in a middle-of-the night house fire I know EMDR helped both of us.
I did the research, I know of all of the studies that say it does work more importantly, I know that my child and I (along with others involved in the fire)can live life without fearing the sound of a siren, the smell of burning wood and the sight of a fireplace.
In fact, last week we had the fire dept in our house because of a bad outlet. My daughter didn't even bat an eye, we were both just fine and all of that credit goes to 6 (between the two of us) EMDR sessions.

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8. forensicpsych
09:28 AM 1/8/08

An unfortunate example of substandard journalism this time in the Scientific American ignoring the evidence that EMDR is clearly a superior treatment to CBT/Exposure.

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9. Ed Hallsten Ph.D.
03:13 AM 1/10/08

In addition to what Patti Levin cited in her earlier post, I would add what I consider some very relevant research information for prospective consumers of PTSD treatment. Dr. Tonya Edmond has brought to this issue qualitative published research data on how adult females with histories of significant Child Sexual Abuse (CSA) were impacted by their therapy experience. In her study, EMDR and eclectic groups each had significant positive effects compared to the control group as measured by four standardized quantitative measures, but there were no significant outcome differences between them on those measures □ a fairly typical outcome in research reported by other respondents. However, the EMDR group did report significantly greater problem resolution than the eclectic therapy group on the subjective quantitative measures.
The most interesting differences, however, were in the qualitative individual assessments of the therapy experience □ data from individual standard interviews asking clients what the experience was like for them and what differences it made for them. The eclectic group typically stated that the relational

quality of their experience was the most helpful component, and their benefits from treatment were described in terms of increased resources and ability to deal with their distress, improved perceptions of themselves, and increased power and potential for going on with life in spite of the issues with past problems. However none of the 20 respondents from this group stated that the problem they chose to address in the six treatment sessions had been resolved -- these targets would benefit from further treatment.

In the EMDR group, clients identified the EMDR procedures and process as the major component contributing to the effectiveness of their treatment. None of them commented about the relational aspects of treatment unless prompted to do so. However, half of this group stated that the targets chosen to be addressed in treatment were resolved -- concluded, done, finished -- and they did not contemplate any further need of treatment for them. About half of the others in the EMDR group were less certain that the selected issues were fully resolved and stated that additional therapy might be needed. The remaining quarter stated it was probable that they would seek additional treatment for the issues they had worked on.

To me, Dr. Edmond□s work suggests strongly that treatments that appear equally effective by widely accepted quantitative measures may be seen to provide qualitatively very different outcomes when client-focused questions are asked. Her studies also seem to me to suggest that if you want help to live more effectively with past trauma, several treatment options can be considered. But if you want to really be done with the negative and disagreeable ongoing residuals of past trauma, then the options are more limited and EMDR emerges as the major contender.

Much more of this qualitative type of research needs to be done with a focus not only on clients, but also on family members, employers, etc., if we are to have anything like a complete picture of what is going on.

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10. awriter
04:50 PM 7/7/08

This comment is based on actual experience using current methods to help me with anxiety and trauma.

The article states:
So, now to the bottom line: EMDR ameliorates symptoms of traumatic anxiety better than doing nothing and probably better than talking to a supportive listener.

I am fearless and not affected by my traumatic experience anymore after using EMDR. I did not experience this with other methods of twenty years of therapy, combined with only two prescriptions for ativan lasting only a few months during the deaths of close family members. My life is no longer fear based after EMDR. I feel like I can be a contributing member to society now, and hope this comment helps many doctors and therapists take a close look at this type of therapy. My

trauma occurred at three years of age, and was extreme, lasting for many days. I had a wonderful support system throughout my life, a healthy family upbringing. This can help isolate the effects of the trauma I experienced and the effects of the therapies that were offered to me.

The article also states:
Yet not a shred of good evidence exists that EMDR is superior to exposure-based treatments that behavior and cognitive-behavior therapists have been administering routinely for decades.

This is true. A person afraid of elevators can be desensitized with great benefits with current behavior therapies. Anxieties resulting from traumatic experiences that cannot be practically treated with immersion therapy or exposure based therapy due to the natures of the trauma need another modality. For instance, if the trauma is due to criminal or insane behaviors by another, due to mass deaths and exposure to bombings or war, EMDR can intervene and help the brain process the event (s), and the patient can recover. EMDR does not have to compete with previous proven methods. EMDR only fills in where other methods are not working.

The article also states:
Paraphrasing British writer and critic Samuel Johnson, Harvard University psychologist Richard McNally nicely summed up the case for EMDR: □What is effective in EMDR is not new, and what is new is not effective.□
I would have to disagree if this implies that EMDR is not effective. This statement is unclear.

| Jump To: 1-10 | 11-20 |

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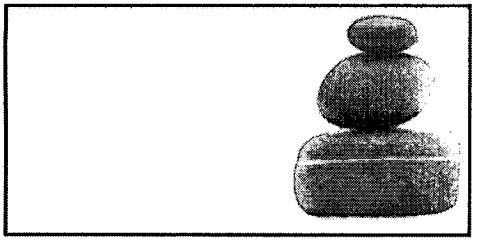

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EMDR Comprehensive Training: For Licensed Mental Health Professionals

Filed under Events, Professional Trainings, Programs, Psychology.
January 20, 2011

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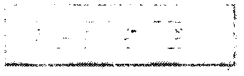

To register call 212-219-2527 x 2
Laurel Parnell, PhD

Eye Movement Desensitization and Reprocessing (EMDR) is a powerful therapy for treating trauma-based problems. This revolutionary therapy has helped thousands of clients recover from such traumas as war, accidents, assaults, disasters and childhood abuse. In addition to the treatment of post-traumatic stress disorder, EMDR is also used to treat the psychological effects of smaller traumas that manifest as symptoms of depression, anxiety, phobias, low self-esteem, creativity blocks and relationship difficulties. Not only does healing occur much more rapidly than in traditional therapy, but as a result of EMDR's clearing of emotional and physical blockages, many people undergo spiritual transformation and have "beyond the ego" experiences using the technique.

Parts 1 & 2: Beginning Through Advanced Level EMDR

In this training, which covers both EMDR Parts 1 and 2, we will learn the history and development of EMDR; the EMDR model and components of treatment; its eight phases of treatment;how to evaluate clients to gauge the appropriateness of EMDR treatment; how to prepare clients for EMDR trauma processing; protocols and procedures for using EMDR for a range of problems; and how to use EMDR as a form of transpersonal psychotherapy.

Using lecture, small group practice and demonstrations in a supportive environment, we will learn beginning through advanced level EMDR. Because this course provides extensive time for practice, we will learn EMDR from the inside out, experiencing firsthand the power of this transformative therapy.

Note:
• To meet the requirements for basic EMDR training, participants must complete Parts 1 and 2, receive 10 hours of consultation from EMDRIA-approved consultants and then complete Part 3.
• Required reading: *Laurel Parnell's A Therapist's Guide to EMDR: Tools and Techniques for Successful Treatment*
• Recommended reading: Laurel Parnell's *Transforming Trauma:EMDR* and *EMDR in the Treatment of Adults Abused as Children*, and Francine Shapiro's *EMDR: Eye Movement Desensitization and Reprocessing*
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Part 3: Transforming Trauma with EMDR: Advanced Clinical Workshop and Refresher Course

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The full course will involve reviewing standard EMDR protocol and procedures, and learning a modified protocol (and when to use it); a technique for target development; techniques for resource development and installation; and the advanced use of interweaves. We will also learn how to work with complex cases; use EMDR with critical incidents, grief and loss, medical procedures, traumas and somatic disorders; understand EMDR's capacity to act as a transpersonal psychotherapy; and successfully integrate EMDR into a clinical practice.

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Sunday, 9am–12:30pm

For more information, or to register by phone, call 212-219-2527 ext. 2.

Laurel Parnell, PhD

Laurel Parnell, PhD, is an internationally recognized clinician, consultant, EMDR trainer, and author of three books, including A Therapist's Guide to EMDR that this training is based on. A meditation practitioner for over 3(years, she teaches EMDR from a transpersonal perspective and maintains a private practice in San Rafael, California.

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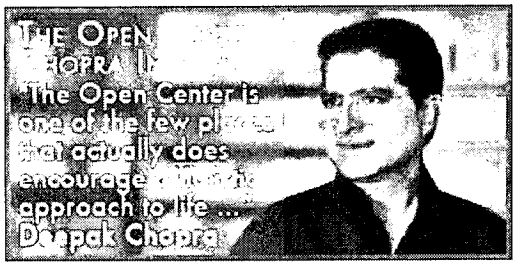

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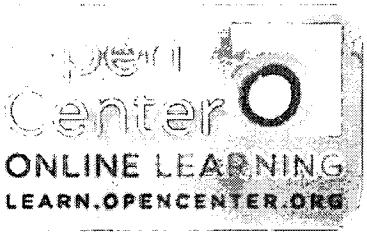

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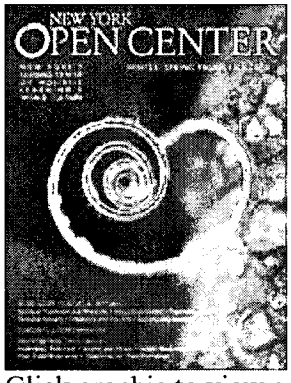

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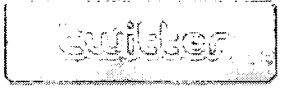

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Journal of Consulting and Clinical Psychology
Volume 69, Issue 2, April 2001, Pages 305-316

Eye Movement Desensitization and Reprocessing (EMDR): A Meta-Analysis*1

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Department of Psychiatry, Queen's University, Kingston, Ontario, Canada

Received 11 January 2000; revised 3 August 2000; accepted 4 August 2000.
Available online 6 August 2002.

Abstract

Eye movement desensitization and reprocessing (EMDR), a controversial treatment suggested for posttraumatic stress disorder (PTSD) and other conditions, was evaluated in a meta-analysis of 34 studies that examined EMDR with a variety of populations and measures. Process and outcome measures were examined separately, and EMDR showed an effect on both when compared with no treatment and with therapies not using exposure to anxiety-provoking stimuli and in pre–post EMDR comparisons. However, no significant effect was found when EMDR was compared with other exposure techniques. No incremental effect of eye movements was noted when EMDR was compared with the same procedure without them. R. J. DeRubeis and P. Crits-Christoph (1998) noted that EMDR is a potentially effective treatment for noncombat PTSD, but studies that examined such patient groups did not give clear support to this. In sum, EMDR appears to be no more effective than other exposure techniques, and evidence suggests that the eye movements integral to the treatment, and to its name, are unnecessary.

*1 We acknowledge the ongoing support of this and other research by the Hotel Dieu Hospital, Kingston, Ontario, Canada.

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Journal of Consulting and Clinical Psychology
Volume 69, Issue 2, April 2001, Pages 305-316

What is EMDR?

Eye Movement Desensitization and Reprocessing (EMDR) is an integrative psychotherapy approach that has been extensively researched and proven effective for the treatment of trauma. EMDR is a set of standardized protocols that incorporates elements from many different treatment approaches. To date, EMDR has helped an estimated two million people of all ages relieve many types of psychological stress. Read **EMDRIA's clinical definition of EMDR**.

Additional information about EMDR is available to the public in the "What is EMDR?" brochure and to mental health professionals in "EMDR: Information for Professionals" brochure. Copies may be purchased at the **EMDR International Association Store**.

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Eye Movement Desensitization and Reprocessing (EMDR)[1] is a comprehensive, integrative psychotherapy approach. It contains elements of many effective psychotherapies in structured protocols that are designed to maximize treatment effects. These include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies[2].

EMDR psychotherapy is an **information processing therapy** and uses an eight phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviors and mental health.

During treatment various procedures and protocols are used to address the entire clinical picture. One of the procedural elements is "dual stimulation" using either bilateral eye movements, tones or taps. During the reprocessing phases the client attends momentarily to past memories, present triggers, or anticipated future experiences while simultaneously focusing on a set of external stimulus. During that time, clients generally experience the emergence of insight, changes in memories, or new associations. The clinician assists the client to focus on appropriate material before initiation of each subsequent set.

Eight Phases of Treatment

The first phase is a history taking session during which the therapist assesses the client's readiness for EMDR and develops a treatment plan. Client and therapist identify possible targets for EMDR processing. These include recent distressing events, current situations that elicit emotional disturbance, related historical incidents, and the development of specific skills and behaviors that will be needed by the client in future situations.

During the second phase of treatment, the therapist ensures that the client has adequate methods of handling emotional distress and good coping skills, and that the client is in a relatively stable state. If further stabilization is required, or if additional skills are needed, therapy focuses on providing these. The client is then able to use stress reducing techniques whenever necessary, during or between sessions. However, one goal is not to need these techniques once therapy is complete.

In phase three through six, a target is identified and processed using EMDR procedures. These involve the client identifying the most vivid visual image related to the memory (if available), a negative belief about self, related emotions and body sensations. The client also identifies a preferred positive belief. The validity of the positive belief is rated, as is the intensity of the negative emotions.

After this, the client is instructed to focus on the image, negative thought, and body sensations while simultaneously moving his/her eyes back and forth following the therapist's fingers as they move across his/her field of vision for 20-30 seconds or more, depending upon the need of the client. Athough **eye movements** are the most commonly used external stimulus, therapists often use auditory tones, tapping, or other types of tactile stimulation. The kind of dual attention and the length of each set is customized to the need of the client. The client is instructed to just notice whatever happens. After this, the clinician instructs the client to let his/her mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind. Depending upon the client's report the clinician will facilitate the next focus of attention. In most cases a client-directed association process is encouraged. This is repeated numerous times throughout the session. If the client becomes distressed or has difficulty with the process, the therapist follows established procedures to help the client resume processing. When the client reports no distress related to the targeted memory, the clinician asks him/her to think of the preferred positive belief that was identified at the beginning of the session, or a better one if it has emerged, and to focus on the incident, while simultaneously engaging in the eye movements. After several sets, clients generally report increased confidence in this positive belief. The therapist checks with the client regarding body sensations. If there are negative sensations, these are processed as above. If there are positive sensations, they are further enhanced.

In phase seven, closure, the therapist asks the client to keep a journal during the week to document any related material that may arise and reminds the client of the self-calming activities that were mastered in phase two.

The next session begins with phase eight, re-evaluation of the previous work, and of progress since the previous session. EMDR treatment ensures processing of all related historical events, current incidents that elicit distress, and future scenarios that will require different responses. The overall goal is produce the most comprehensive and profound treatment effects in the shortest period of time, while simultaneously maintaining a stable client within a balanced system.

After EMDR processing, clients generally report that the emotional distress related to the memory has been eliminated, or greatly decreased, and that they have gained important cognitive insights. Importantly, these emotional and cognitive changes usually result in spontaneous behavioral and personal change, which are further enhanced with standard EMDR procedures.

---

[1]Shapiro, F. (2001). Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (2nd ed.). New York: Guilford Press.

[2]Shapiro, F. (2002). EMDR as an Integrative Psychotherapy Approach: Experts of Diverse Orientations Explore the Paradigm Prism. Washington, DC: American Psychological Association Books.

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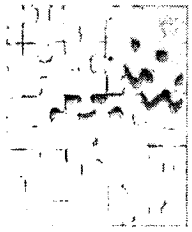

Frequently Asked Questions

1. Does EMDRIA provide basic training in EMDR?

EMDRIA sets the standards and grants approval to individuals or organizations to provide basic training in EMDR.

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2. Are "EMDRIA Membership" and "Certification in EMDR" the same thing?

"EMDRIA Membership" and "Certification in EMDR" are completely separate of each other. Many of our Members confuse these two programs. Membership in EMDRIA affords you the benefits that can be found here. Certification in EMDR is just

that – Certification. There is a separate application process and criteria that clinicians must complete before they may apply for Certification.

There has also been confusion between the renewals for Membership vs. renewals for Certification and Approved Consultants. The first thing to look at is the heading. It will indicate whether it is a Membership Renewal or a Certification/Approved Consultant Renewal. Your Membership Renewal comes out at the end of each calendar year, usually sometime in November. Certification and Approved Consultant Renewals, on the other hand, are sent out 60 to 90 days prior to your certification expiration date, which could be any month of the year, dependent upon the approval date of your application. Those of you who applied for Certification or Approved Consultant between the months of November and January may easily confuse the two Renewals, since you probably receive them near the same time. When in doubt, please feel free to contact our office for assistance.

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3. Does completion of basic training in EMDR means that you are Certified in EMDR?

Completion of basic EMDR training is just that – completion. Certification is an advanced process, which is only offered through EMDRIA.

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4. I'm a member of EMDRIA, but I'm not listed on the website. Why is that?

All members of EMDRIA are listed on the website in the "Members Only" section (in the Member Directory).

All Full Members of EMDRIA, along with those who are Certified and Approved Consultants, are listed in the "Find a Therapist" section of the website; and the list notes the various designations (Full Member, Certified in EMDR, Approved Consultant in EMDR).

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5. Are EMDR International Association, EMDR Institute, and EMDR Humanitarian Assistance Programs al affiliated?

EMDR International Association (EMDRIA) is not affiliated with either the EMDR Institute or EMDR Humanitarian Assistance Programs (HAP). The EMDR Institute is a for-profit training organization. EMDR HAP is a non-profit 501(C)(3) organization EMDRIA is a non-profit 501(C)(6) organization. The EMDR Institute is **one of many** Providers of Basic EMDR Training tha EMDRIA has approved. They have also been approved as an EMDRIA Credit Provider for advanced EMDR programs tha they offer. (*Basic EMDR training is not considered an advanced EMDR program and is not awarded EMDRIA Credits*). EMDR HAP is also approved by EMDRIA as an Approved Provider of Basic EMDR Training. We are all a part of the ***EMDR community***, and we do provide reports from EMDR HAP in our Newsletter from time to time, but our businesses are completely separate and not affiliated.

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6. Does EMDRIA maintain a general EMDR listserv?

Currently, EMDRIA maintains the following listservs– one for Clinician Support in Disaster Response, one for EMDRIA Regional Coordinators, one for Researchers, and listservs for the EMDRIA Child Special Interest Group and Military Special Interest Group. A new listserv for Public Practice & Diversity is in development and will be available to members working in public agency settings soon. We hope to expand this service to evrn more areas for members in the future.

According to responses received from our Member Survey and from emails and phone calls we receive on a regular basis, many members think that EMDRIA provides a general EMDR listserv, but this is a service that the EMDR Institute provides to those people who have been trained by the EMDR Institute, and is not affiliated with EMDRIA.

EMDRIA does offer members the opportunity to interact through the online EMDRIA Forum. Using the Forum, members can post clinical questions and other members can respond with useful information. This feature can be found in the "Members Only" section of the website.

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7. Must members obtain EMDRIA Credits (Continuing Education in EMDR) to maintain their membership in EMDRIA?

Members are only required to pay their annual dues (at their highest level of eligibility) and subscribe to EMDRIA's Code of Conduct to maintain their membership. EMDRIA Credits are only "required" for obtaining designations of Certification in EMDR or Approved Consultant in EMDR. However, we encourage all members to attend programs such as these in order to keep up with the most current ways in which to utilize EMDR. EMDRIA also has a Blog that provides a medium for members, non-members and the public to post comments and share ideas.

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CenterPoint - EMDR and Life Enhancement Counseling

What is EMDR?

Eye Movement Desensitization and Reprocessing (EMDR) is a psychological method that helps people to quickly process and heal from the emotional distress that lodges in their minds following traumatic incidents. Repeated studies show that by using EMDR in as few as three sessions, trauma survivors can experience benefits that once took years in more traditional forms of therapy (see the Journal of Anxiety Disorders, vol.13,1999).There are nearly 30,000 licensed EMDR practitioners worldwide who have successfully treated over two million clients. EMDR has strong empirical support and rapidly increasing recognition and acclaim. There are approved EMDR training courses at universities and medical centers such as the University of Colorado Health Sciences, Upstate Medical University, Menninger School of Psychiatry and Mount Sinai Medical Center. This application of EMDR to treating trauma and other specific upsetting experiences is what we like to call **Therapeutic EMDR**.

In addition to treating trauma, practitioners have discovered that EMDR also is very effective in helping people overcome more common "blocks" in thinking and negative emotions that prevent them from achieving a more satisfying life. Overcoming these obstacles to finding increased fulfillment in relationships, work, and play is what we call **Life Enhancement EMDR**.

Sometimes in traditional forms of therapy, clients making good progress can get stuck in some areas. Supplementary EMDR interventions may help the client break through that impasse and continue moving forward in the therapy. We call this **Adjunctive EMDR**.

What does EMDR stand for?

Eye Movement: All forms of EMDR use "bilateral stimulation." Early clinical research showed that alternating eye movement accelerates the clearing of stress symptoms and opens the brain up to new, more productive ways of thinking and feeling. The mechanism by which this takes place may involve guiding the brain gently into optimal "duel attention," to both internal and external information. More recent research shows that other forms of stimulation also work well, such as alternating left and right taps, tones, or music specially designed to move the brain's awareness back and forth between the right and left sides. The effect of EMDR in stimulating new and more productive ways of thinking makes it useful for enhancing life in a wide variety of ways.

Desensitization: refers to the removal of the emotional disturbance associated with a traumatic memory, or the removal of any negative feeling that blocks one's progress in life.

Reprocessing: refers to the replacement of unhealthy, negative beliefs and feelings with more positive ones. The unhealthy mental states which are reprocessed may be those associated with a traumatic memory, or any negative mental state that prevents one from attaining a more fulfilling life.

Professional and governmental endorsements of EMDR

EMDR has been endorsed in multiple evidence-based practice guidelines from respected professional and governmental organizations, for example:

1) **The United States Department of Defense and Veteran's Administration**: VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress awarded EMDR the highest level of recommendation, citing it, along with Cognitive Therapy , Exposure Therapy and Stress Inoculation

Training as having "significant benefit" for the reduction of symptom severity and improved global functioning. (http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=5187&nbr=3569)

2) **The American Psychological Association's Division of Clinical Psychology** : placed EMDR, exposure therapy, and stress inoculation therapy on a list of empirically supported treatments, as "probably efficacious for civilian PTSD", no other therapies were judged to be empirically supported by controlled research for PTSD populations (Chambless, D.L.,et al (1998) Update on empirically validated therapies II. The Clinical Psychologist, 51, 3-16.)

3) **International Society for Traumatic Stress Studies**: EMDR was found to be an efficacious treatment for PTSD (Posttraumatic Stress Disorder) indicated by the highest scientific standard based upon a review of seven published, randomized, controlled studies with overall large effect sizes (Foa, E. B., Keane, T. M., & Friedman, M. J. (2000), Guidelines for treatment of PTSD. Journal of Traumatic Stress, 13, 539-588)

4) **The United Kingdom Department of Health** (2001): their evidence based treatment guidelines recommend EMDR as an efficacious treatment for PTSD (United Kingdom Department of Health, 2001, Treatment choice in psychological therapies and counselling: Evidence based clinical practice guideline. London, http://www.doh.gov.uk/mentalhealth/treatmentguideline/)

5) **Israeli National Council for Mental Health**: recommends EMDR in their guidelines for treatment of victims of terror (Belich, A., Kotler, M., Kutz, E., & Shaley, A. (2002). A position paper of the Israeli National Council for Mental Health: Guidelines for the assessment and professional intervention with terror victims in the hospital and in the community.)

6) **Northern Ireland Department of Health**: recommends EMDR in their evidence based treatment guidelines (Northern Ireland Department of Health. (2001). Treatment choice in psychological therapies and counselling evidence based clinical practice guideline. London , http://www.doh.gov.uk/mentalhealth/treatmentguideline/)

7) **United States Federal Bureau of Investigation (FBI)**: EAP administrators endorse the therapeutic use of EMDR for their agents who have been through violent events ("The FBI has found EMDR to be extremely effective when used on individuals exhibiting symptoms of post-traumatic stress, which can be tied to a specific traumatic event. The bottom line as I see it is that it works." ~ Charles McCormick, FBI Administrator, Employee Assistance Program)

"The FBI has found EMDR to be extremely effective when used on individuals exhibiting symptoms of post traumatic stress, which can be tied to a specific traumatic event. The bottom line as I see it is that it works." -- Charles McCormick, Unit Chief, Federal Bureau of Investigation Administrator, Employee Assistance Program	"EMDR is...ideal for those who have been unable to forget past traumatic life events, as it allows for a rapid processing of even deeply rooted memories, giving individuals back control of their lives and their emotions." -- Dusty Bowencamp, RN, CTR, Disaster Mental Health, American Red Cross	"During the last 20 years, I have been working with emergency services personnel, who have been stressed by the traumatic events they handle in the workplace. For many, EMDR has been one of the most effective therapeutic interventions available." -- Jeffrey T. Mitchell, Ph.D., President, International Critical Incident Stress Foundation, Clinical Associate Professor of Emergency Health Services, University of Maryland.

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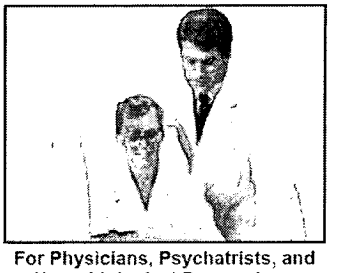
Welcome to EMDR Network

EMDR Network provides access to information important for clients and clinicians. The organizations listed on this website are well-established and professionally scrutinized to uphold the highest standards.



For Physicians, Psychatrists, and Neurobiological Researchers

EMDR is an Effective Form of Therapy for Trauma.

EMDR is a therapy that is listed in the new Department of Veterans Affairs & Department of Defense Practice Guidelines "A" category as "highly recommended" for the treatment of trauma.

See **http://www.oqp.med.va.gov/cpg/PTSD/PTSD_cpg/frameset.htm** for more information.

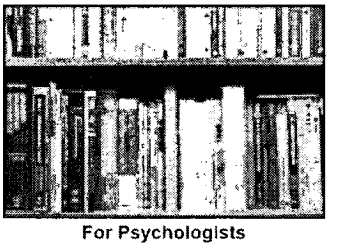
It has received a high level of recommendation by the American Psychiatric Association and by the mental health departments of Israel, Northern Ireland, United Kingdom, France, Sweden and more.

For a full listing visit **http://www.EMDRHAP.org/researchandresources.htm**

EMDR is also listed as an effective form of therapy, backed by research, on a new National Institute of Mental Health sponsored website: Check under "Adult MH Therapist for Post-traumatic Stress Disorder."

See **http://www.therapyadvisor.com/**

For Marriage, Family and Child Therapists



For Psychologists

For Therapists Working with War and Disaster Victims

EMDR - Humanitarian Assistance Programs

Our mission

The Mission of EMDR Humanitarian Assistance Programs is to build capacity for effective treatment of traumatic stress disorders in under served communities anywhere in the world.

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Contact Information:
Mailing Address:
EMDR HAP
2911 Dixwell Avenue, Ste. 201
Hamden, CT 06518
Phone: (203) 288-4450
Fax: (203) 288-4060
Email EMDR HAP

Continuing Education Info:

Read about EMDR accomplishments.

Make a donation to assist us in our Efforts.

Our goal is to break the cycle of suffering that ruins lives and devastates families.

EMDR-Humanitarian Assistance Programs (HAP), a 501(c)(3) nonprofit organization, can be described as the mental health equivalent of Doctors Without Borders: a global network of clinicians who travel anywhere there is a need to stop suffering and prevent the after-effects of trauma and violence.

Our primary focus is on training local therapists within crisis or underserved communities to treat trauma using EMDR (Eye Movement Desensitization and Reprocessing), a therapeutic approach that has been proven effective for post-traumatic stress disorder in numerous controlled studies.

The HAP model emphasizes training and empowering local clinicians to continue the healing process.

EMDR becomes a powerful weapon for battling the after-effects of trauma, whether from natural or man-made disaster. We also help local therapists and organizations set up infrastructures to support ongoing direct service to their communities. In this way, the healing power of EMDR is increased exponentially, continuing long after HAP clinicians leave an area.

For more information on EMDR as a therapy, its applications, and how to access EMDR services, we recommend a visit to the **EMDR NETWORK**

Our Trauma Recovery Network coordinates clinicians to treat victims and emergency service workers after crises such as Hurricane Katrina, the Oklahoma City bombing and the 9/11 terrorist attacks.

HAP in Haiti: First Encounters and Future Plans

Thanks to an energetic response from donors, HAP was able to send two seasoned disaster responders into Haiti in late February, where they treated over 100 children in an orphanage near Port au Prince, using the group process for children. They also assessed the potential for training Haitian therapists and made some promising contacts. At this point, we are working toward a first sequence of Basic EMDR training for Haitian psychologists in the later part of April. We thank all donors whose generosity has made this possible. We also know that more than a single round of training (Parts I and II) will be needed, so our quest for funds earmarked for Haiti continues.

Vivian Lamphear, PhD from California and Roger Ludwig, MA from Cheyenne, were HAP's first emissaries. Vivian has spent many years in Haiti working as a researcher and EMDR clinician with numerous church communities and church-related social services. Vivian has returned on a second trip to work with additional church communities and to do important groundwork for setting up EMDR training. And Roger has written a moving first-person account that will engage all EMDR clinicians.

To read all of Roger Ludwig's first-hand account, **click here**

Hap in Action

How well is the US government addressing the needs of military personnel and veterans with combat PTSD?

View and download this extensive overview by CDR Mark Russell USN, a leading authority, as presented at 2008 EMDRIA

Conference.

March 1, 2011

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Eye Movement Desensitization and Reprocessing (EMDR)

Please note new information dealing with EMDR treatment

Post-traumatic stress disorder, like any other psychological trauma, is difficult to diagnose, and often, even more difficult to treat. But a team of psychotherapists at the North Chicago VA Medical Center's PTSD Treatment Clinic is finding that a somewhat physical procedure may indeed offer some success. Physically, Eye Movement Desensitization and Reprocessing (EMDR) is as simple as a therapist waving a hand in front of a patient's face, but it is what happens at the psychological level that is much more complicated and controversial. EMDR is currently endorsed under the VA/DoD Clinical Practice Guidelines for the Management of Post-Traumatic Stress Disorder as a treatment of "significant benefit."

Eye Movement Desensitization and Reprocessing (EMDR) is a relatively new clinical treatment that has been scientifically evaluated primarily with trauma survivors. EMDR's originator, Dr. Francine Shapiro, describes the procedure in detail in a recent book, and advises that therapists use EMDR only after completing an authorized advanced training in EMDR. When considering the possibility that EMDR may be helpful for you or someone you know, an important first step is to speak with therapist(s) who have had advanced EMDR training and are experienced in selecting clients and successfully conducting EMDR. For information on qualified EMDR therapists, contact the International EMDR Network (P.O. Box 51038, Pacific Grove, California 93950).

EMDR is widely used by psychotherapists with adult trauma survivors, including war veterans, abuse and rape survivors, and accident and disaster survivors. EMDR also is used with traumatized children and with adults suffering from severe anxiety or depression.

Briefly, in EMDR a qualified therapist guides the client in vividly but safely recalling distressing past experiences ("desensitization") and gaining new understanding "reprocessing") of the events, the bodily and emotional feelings, and the thoughts and self-images associated with them. The "eye movement" aspect of EMDR involves the client moving his/her eyes in a back-and-forth ("saccadic") manner while recalling the event(s).

EMDR has shown evidence of therapeutic effectiveness in several

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recent scientific studies. After receiving between one and twelve sessions of EMDR, many (but not all) adolescents and adult clients have reported a variety of benefits. EMDR recipients in these studies have included adult and adolescent child and domestic abuse survivors, combat veterans, rape and violent assault survivors, victims of life-threatening accidents and disasters, and individuals with severe panic attacks or depression. Some of these individuals were seeking help from the VA, from their HMO medical plan, or from mental health specialists at clinics or counseling centers, while others were not actively seeking health care or mental health treatment, but agreed to participate in a research study in order to receive treatment. The benefits reported following EMDR include:

- Feeling less troubled by trauma memories and reminders while awake and in their dreams (PTSD intrusive reexperiencing symptoms)
- Feeling able to cope with trauma memories and reminders without simply trying to avoid troubling thoughts, conversations, people, activities, or places (PTSD avoidance symptoms)
- Feeling more able to enjoy pleasurable activities and to be emotionally involved in relationships, as well as feeling that there is a future to look forward to (PTSD numbing and detachment symptoms)
- Feeling less tense, stressed, irritable or angry, easily startled, and on-guard, and more able to sleep restfully, concentrate on activities, and deal with pressure and conflict (PTSD hyperarousal/hypervigilance symptoms)
- Feeling less anxious, worried, fearful or phobic, and prone to panic attacks
- Feeling less depressed (down and blue, hopeless, worthless, emotionally drained, or suicidal)
- Feeling an increased sense of self-esteem and self-confidence

A few studies have checked to see how participants were doing several months or more than a year after completing EMDR, generally finding that the benefits persisted over these time periods.

However, EMDR is not a certain cure, nor always effective. In even the most successful studies approximately 25-33% of participants report no clear benefit. EMDR's most consistent benefit is helping clients to feel better about themselves because they feel less troubled by and more able to cope with trauma memories. EMDR is less likely to actually change how much bodily arousal and mental hypervigilance trauma survivors experience -- although such changes do occur at times.

EMDR also is not always the best treatment to deal with PTSD or

related psychological problems. One study with Vietnam military veterans diagnosed with PTSD showed EMDR to be no better than other widely used forms of counseling. Another study with spider phobic children showed EMDR to be less helpful than an "in vivo exposure" treatment in which the children gradually and safely saw and touched a variety of real or artificial spiders.

EMDR involves carefully but intensively confronting very frightening or disturbing memories. Some clients report that the eye movement feature of EMDR helped them to rapidly feel less terrified, intimidated, or hopeless while undergoing this therapeutic "exposure" to sources of fear, anxiety, or depression. However, several studies suggest that "direct therapeutic exposure" by vividly and safely confronting stressors *without eye movements* is *equally as effective* as EMDR. These studies, with combat veterans or civilian trauma survivors diagnosed with PTSD, and with adults with phobias or panic disorder, raise the question of whether eye movements are essential to the positive results that can occur following EMDR.
That question remains unanswered.

If you or someone you know are considering undergoing EMDR, you should be aware, however, that PTSD is a complex and devastating disorder. No single procedure can "cure" PTSD. The best treatment plan is based upon a thorough professional assessment, and may include individual therapies such as EMDR or therapeutic exposure, but also a range of other appropriate services such as group and family therapy, addiction care, medication, stress and anger management, vocational therapy, and health care. EMDR, like any other therapy, should be done with these basic guidelines:

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(3) vividly and without avoiding any aspect of the experience, however stressful

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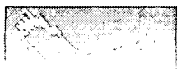

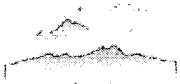

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- **EMDR therapy was determined to be an effective treatment of trauma.**

Department of Veterans Affairs and Department of Defense (2004). *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress.* Washington, DC.

- **EMDR therapy was placed in the "A" category as "strongly recommended" for the treatment of trauma.**

18 randomized controlled (and 12 nonrandomized) studies have been conducted on EMDR in the treatment of trauma.
For the full research list:
Click Here

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EMDRIA
EMDR INTERNATIONAL ASSOCIATION

EMDR International Association

The EMDR International Association (EMDRIA) is a professional association where EMDR practitioners and EMDR researchers seek the highest standards for the clinical use of EMDR. EMDR is an accepted psychotherapy by leading mental health organizations throughout the world for the treatment of a variety of symptoms and conditions. This website provides information to the greater EMDR community including clinicians, researchers, and the public that our members serve. *Scott Blech,CAE, Executive Director*

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EMDR Therapeutic Interweave Treatment Manual
Ginger Gilson, MFT & Sandra Kaplan, MSW
A Manual For EMDR Trained Clinicians. Gives structured framework of 16 categories of Therapeutic Interweave; and gives strategies that enhance safety, assist with affect regulation, self-soothing, and develop ego-strength. Available through EMDR HAP. **Click here** for more information.

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Mark Grant
An "information-processing" based approach to the psychological management of pain utilizing EMDR. Manual includes theory, assessment and clinical application of specialized protocols. Available through EMDR HAP. **Click here** for more information.

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The following links are provided for your convenience. These organizations are not affiliated with the EMDR Institute or Francine Shapiro, PhD.

Click on the organization's name to proceed to the associated website.

EMDRIA (EMDR International Association)

HAP (EMDR Humanitarian Assistance Programs)

EMDR Argentina

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EMDR France

EMDR Germany

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EMDR Ibero America

EMDR Israel

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EMDR UK and Ireland

EMDR Uruguay

the Skeptic's Dictionary

A Collection of Strange Beliefs, Amusing Deceptions, and Dangerous Delusions

eye movement desensitization and reprocessing (EMDR)

> *....what is new in EMDR does not appear to be helpful, and what is helpful is what we already know about relaxation, education, and psychotherapy.**
>
> *Although the research regarding the necessity of the eye movement component is currently inconclusive, EMDR is a psychological treatment for PTSD which has received considerable empirical validation (Carlson et al., 1998; Marcus et al., 1997; Rothbaum, 1997; Scheck et al., 1998; Wilson et al., 1995). However, in spite of the empirical validation, confusion still exists in the literature regarding EMDR. Some of the confusion is theoretical and due to the current lack of empirical validation of Shapiro's (1991b, 1995) information processing model and the continued inability of other models (e.g., exposure) to convincingly explain EMDR methods and effects.**

EMDR is a therapeutic technique in which the patient moves his or her eyes back and forth, hither and thither, while concentrating on "the problem." The therapist waves a stick or light in front of the patient and the patient is supposed to follow the moving stick or light with his or her eyes. The therapy was discovered by therapist Dr. Francine Shapiro while on a walk in the park. (Her doctorate was earned at the now defunct and never accredited Professional School of Psychological Studies. Her undergraduate degree is in English literature.*) It is claimed that EMDR can "help" with "phobias, generalized anxiety, paranoid schizophrenia, learning disabilities, eating disorders, substance abuse, and even pathological jealousy" (Lilienfeld 1996), but its main application has been in the treatment of post traumatic stress disorder (PTSD). No one has been able to adequately explain how EMDR is supposed to work. Some think it works something like acupuncture (which allegedly unblocks chi): rapid eye movements allegedly unblock "the information-processing system." Some think it works by a sort of ping-pong effect between the right and left sides of the brain, which somehow restructures memory. Or perhaps it works, as one therapist suggested, by the rapid eye movements sending signals to the brain which somehow tame and control the naughty part of the brain which had been causing the psychological problems. I heard the latter explanation on a television news report (December 2, 1994). The television station provided a nice visual of a cut-away head with sparks flying in the

brain. The anchorman warned us not to try this at home, that only licensed mental health professionals were qualified to give this kind of therapy. One such professional is Dr. Ann T. Viviano, who thinks EMDR works this way: "The client, by following a moving light with their eyes, activates the healing process of the brain, much as what occurs in sleep. As a result, the painful memories are re-processed and the original beliefs which sprang up from them are eliminated. New, healthy beliefs replace these." The healing occurs by activating the healing process.

Evidence for the effectiveness of EMDR's eye movement component is not much stronger than the theoretical explanations for how EMDR allegedly "works." The evidence has the virtue of being consistent, unlike the theoretical explanations, but it is mainly anecdotal and very vague. It has not been established beyond a reasonable doubt by any controlled studies that any positive effects achieved by an EMDR therapist's eye movement techniques are not likely due to chance, the placebo effect, patient expectancy, posthypnotic suggestion, other aspects of the treatments besides the eye movement aspect, etc. This is not to say that there have not been controlled studies of EMDR. Dr. Shapiro cites quite a few, including her own. The reader is invited to look at her summaries of the research and determine for him or herself just how adequate the evidence is in support of EMDR's eye movement component as the main causal agent in recovery from PTSD. One study by Wilson, Becker and Tinker, to be published in *The Journal of Consulting and Clinical Psychology,* reports a "significant improvement" in PTSD subjects treated with EMDR. The study also provides significant evidence that spontaneous healing cannot account for this improvement. Nevertheless, the study is unlikely to convince critics that EMDR's eye movement component is the main causal agent in measured improvement of PTSD subjects. I suspect that until a study is done which isolates the eye movement part from other aspects of the treatment, critics will not be satisfied. It may well be that those using EMDR are effecting the cures they claim and thereby benefiting many victims of horrible experiences such as rape, war, terrorism, murder or suicide of a loved one, etc. It may well be that those using EMDR are directing their patients to restructure their memories, so that the horrible emotive aspect of an experience is no longer associated with the memory of the experience. But, for now, the question still remains, whether the rapid eye movement part of the treatment is essential. In fact, one of the control studies cited by Shapiro seems counter-indicative:

> In a controlled component analysis study of 17 chronic outpatient veterans, using a crossover design, subjects were randomly divided into two EMDR groups, one using eye movement and a control group that used a combination of forced eye fixation, hand taps, and hand waving. Six sessions were administered for a single memory in each condition. Both groups showed significant decreases in self-reported distress, intrusion, and avoidance symptoms (Pitman et al. 1996).

Maybe hand taps will work just as well as eye movements. According to one EMDR practitioner, Dr. Edward Hume,

> ...taps to hands, right and left, sounds alternating ear-to-ear, and even alternating movements by the patient can work instead. The key seems to be the

alternating stimulation of the two sides of the brain.*

According to Dr. Hume, Shapiro now calls the treatment Reprocessing Therapy and says that eye movements aren't necessary for the treatment! Maybe *none* of these movements are needed to restructure memory. In short, EMDR is a scientifically controversial technique at present.* This has not prevented thousands of practitioners from being certificated to practice EMDR by Shapiro and disciples.

EMDR is controversial and although it is not an approved practice of the American Psychological Association (APA), it is not disapproved either. According to Pamela Willenz of the APA Public Affairs Office, the "APA rarely approves or disapproves of therapies. We don't approve or disapprove of EMDR as a therapy. APA does recognize therapies and does recognize EMDR as a type of therapy. We offer CE credits for psychologists wanting to learn EMDR." This practice of the APA to neither approve nor disapprove of therapies tells us more about the APA than it does about EMDR. It might be useful to consumers if the APA would at least distinguish between therapies proven to be effective and those that are controversial. One does not need to be an expert in anything to recognize that EMDR is *a type of therapy*.

Advocates of EMDR claim that it is "a widely validated treatment for Post Traumatic Stress Disorder" and other ailments such as "traumatic memories of war, natural disaster, industrial accidents, highway carnage, crime, terrorism, sexual abuse, rape and domestic violence." [David Drehmer, Ph.D., Licensed Clinical Psychologist & Director, Performance Enhancement Laboratory, Associate Professor of Management, DePaul University, personal correspondence.] What is needed is not proof that PTSD subjects are being helped by the treatment, but that it is the eye movement part of the treatment that is essential. Once that is established, a theory as to how it works would be most gratifying. At present, we are being given theories to explain something that we can't yet be sure is even occurring: that eye movements are restructuring memory. If it turns out that that claim is true, I suggest it will have significance far beyond the treatment of PTSD subjects.

Finally, when evidence came in that therapists were getting similar results to standard EMDR with *blind* patients whose therapists used tones and hand-snapping instead of finger-wagging, Shapiro softened her stance a bit. She admits that eye movement is not essential to eye movement desensitization processing, and claims attacks on her are *ad hominem* and without merit.

update (Dec 20,2000): Ranae Johnson has founded the Rapid Eye Institute on a blueberry farm in Oregon where she teaches Rapid Eye Technology. This amazing new therapy is used "to facilitate releasing and clearing of old programming, opening the way to awareness of our joy and happiness." It helps us "find light and spirituality within us that has always been there." Apparently, people are paying some $2,000 for the training and all the blueberries you can eat.

See also thought field therapy.

reader comments

further reading

books and articles (critical of EMDR)

(thanks to psychologist Dr. Terry Sandbeck)

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EMDR and Fad Therapies by Stuart Losen, PhD The New England Journal of Skepticism Vol. 4 Issue 1 (Winter 2001)

UA Psychologist Labels Popular Trauma Therapy "Pseudoscience"

"Can Eye Movements Cure Mental Ailments?" by Gerald M. Rosen, PhD and Jeffrey Lohr, PhD (National Council Against Health Fraud)

"New Therapy for Trauma Doubted" by Judy Foreman

Mental Help: Procedures to Avoid by Stephen Barrett, M.D.

Questionable Treatments for Learning Disabilities and Autism by Stephen Barrett, M.D.

"Can We Really Tap Our Problems Away? A Critical Analysis of Thought Field Therapy" by Brandon A. Gaudiano and James D. Herbert, *Skeptical Inquirer* July/Aug 2000

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Review of Laurel Parnell's *Transforming Trauma: EMDR The Revolutionary New Therapy for Freeing the Mind, Clearing the Body, and Opening the Heart* by Bryan M. Knight

New PTSD Therapy: Innovative or Smoke and Mirrors? from *Psychiatric News*, a publication of the American Psychiatric Association

The American Academy of Experts in Traumatic Stress

A Critical Evaluation of Current Views Regarding Eye Movement Desensitization and Reprocessing (EMDR): Clarifying Points of Confusion by Byron R. Perkins, Psy.D. Private Practice and Curtis C. Rouanzoin, Ph.D. Hope International University

The EMDR Institute

Last updated 12/09/10

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This page was designed by Cristian Popa.

EMDRIA
EMDR INTERNATIONAL ASSOCIATION

How Was EMDR Developed?

In 1987, psychologist Dr. Francine Shapiro made the chance observation that eye movements can reduce the intensity of disturbing thoughts, under certain conditions.

Dr. Shapiro studied this effect scientifically and, in 1989, she reported success using EMDR to treate victims of trauma in the *Journal of Traumatic Stress.*

Since then, EMDR has developed and evolved through the contributions of therapists and researchers all over the world. Today, EMDR is a set of standardized protocols that incorporates elements from many different treatment approaches.

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EMDR Therapy - Eye Movement Desensitization and Reprocessing

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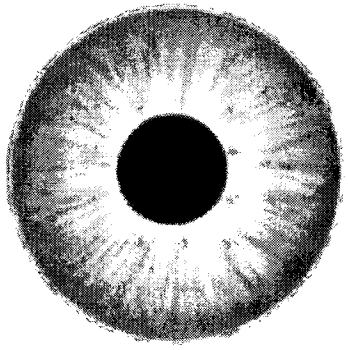

What is EMDR therapy?

Eye Movement Desensitization and Reprocessing

- **EMDR Therapy - Introductory Seminar** open to the Public
- New EMDR Therapy Unlocks the Power of the Mind to Resolve Problems and Pain
- EMDR Therapy : TAMING TRAUMAS
- EMDR Therapy - What People Are Saying

EMDR Therapy (EYE MOVEMENT DESENSITIZATION REPROCESSING):

By Steve B. Reed, L.P.C., L.M.F.T.

Eye Movement Desensitization and Reprocessing (EMDR Therapy) is a new therapeutic technique developed by Francine Shapiro, Ph.D. in 1987. The method was originated by Dr. Shapiro when she noted that disturbing thoughts suddenly disappeared after engaging in a particular type of eye movement. As she deliberately retrieved the disturbing thoughts, they were no longer upsetting to her. This positive effect prompted her to retrieve other disturbing images, engage in the eye movements, and note the result. Upon discovering that a variety of disturbing thoughts and images were no longer upsetting to her, Dr. Shapiro, began a study to note the effects with others. Since 1987 this methodology has evolved into a multifaceted approach to treat a variety of different problems with a wide number of populations. EMDR is frequently used in the treatment of traumatic experiences and the disturbing feelings and thoughts that accompany trauma. Additional uses include resolution of grief, relief from chronic pain, performance enhancement, smoking cessation, depression and dealing with addictions.

The procedure of EMDR treatment involves the client focusing on a disturbing image while the trained therapist facilitates a type of eye movement by having the client follow the movement of the therapist's fingers across the field of vision.

Traumatic images are physiologically and neurologically arousing and this can interfere with the processing of the information in the brain. Consequently, the experience gets misplaced or frozen in our nervous system. The effect of trauma on the brain is like

- Stop emotional eating
- Overcome a fear of heights
- Overcome a fear of flying
- Stop anxiety & depression
- Get relief from Generalized Anxiety Disorder

having a traffic police officer in your brain which gets very tired and sends the distressing signal to an unauthorized parking zone where it gets stored in the wrong area. EMDR retrieves the signal and parks it in the authorized zone.

Researchers do not know why (EMDR Therapy) Eye Movement Desensitization and Reprocessing works. The similarities of the eye movement patterns and Rapid Eye Movement (REM) sleep have contributed to theorizing a connection between the two. Information is processed when dreaming occurs. Dreaming occurs in the stage of sleep known as REM sleep. When the client accesses the disturbing image and thought that accompanies the image while moving their eyes back and forth, the information seems to be processing at an accelerated rate.

With EMDR (Eye Movement Desensitization and Reprocessing), feelings of tension are usually significantly reduced, the image seems to change by fading or becoming more distant, and the power of the negative thoughts are often diminished.

Eye Movement Desensitization and Reprocessing makes the following assumptions about healing:

1. EMDR therapy uncovers hidden aspects of problems.
2. EMDR therapy gets you unstuck and allows a natural movement toward healing.
3. EMDR therapy generates a new perspective of your problem.
4. EMDR therapy allows you to go directly to you healing destination and eliminate incorrect pathways.
5. EMDR therapy creates new pathways beyond the limitations of your previous route.
6. EMDR therapy accesses the natural healing abilities of your deeper self.
7. EMDR therapy enables your ability to let go.
8. EMDR therapy installs positive behaviors and allows you to connect to useful resources within yourself.

The research on EMDR therapy has indicated that the effects remain stable over time. Research on Eye Movement Desensitization and Reprocessing has reported the following positive therapeutic results:

1. Combat veterans who were not able to be free of symptoms no longer experience flashbacks, or nightmares.
2. People with phobias revealed a rapid reduction of fear and symptoms.
3. People with panic disorder reported recovering at a more rapid rate when compared to other treatment methods.
4. Crime survivors and police officers were no longer disturbed by the after effects of violent assaults.
5. People have been relieved of excessive grief due to the loss of a loved one.
6. Children have been symptom free from trauma of assault or natural disaster.
7. Sexual assault survivors were able to lead normal lives and have intimate relationships.
8. Accident and burn survivors who were debilitated are now able to resume productive lives.
9. Those with sexual dysfunction are now able to maintain healthy sexual relationships.
10. Clients with chemical dependency have decreased tendency to relapse and show signs of stable recovery.
11. People with dissociative disorders progress at a rate more rapid than traditional treatment.
12. Clients with a wide variety of PTSD diagnoses experienced relief from symptoms with EMDR.

- **EMDR Training - Introductory Seminar** open to the Public
- **New EMDR Therapy Unlocks the Power of the Mind to Resolve Problems and Pain**
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EMDR NETWORK

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Eye Movements

The benefits of eye movements used in EMDR are still under investigation. The Department of Veterans Affairs & Department of Defense Practice Guidelines **http://www.oqp.med.va.gov/cpg/PTSD/PTSD_cpg/frameset.htm**

have stated that evidence the eye movements are NOT effective is flawed. They also cite 8 controlled studies that show eye movements decrease the negative effects of emotions and imagery. These studies are:

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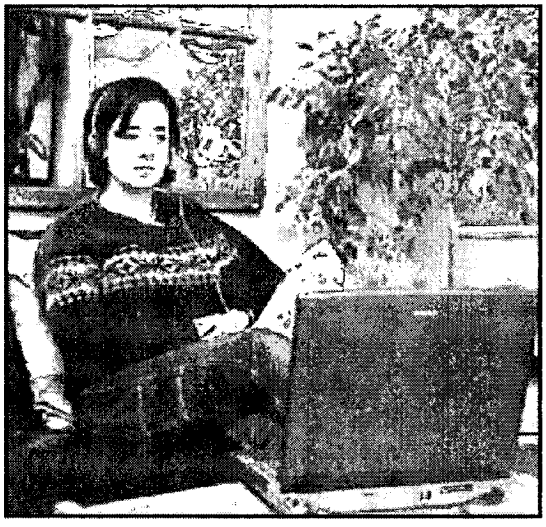

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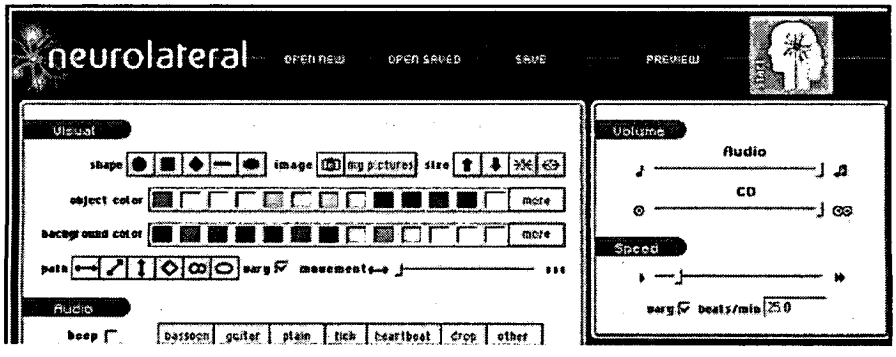

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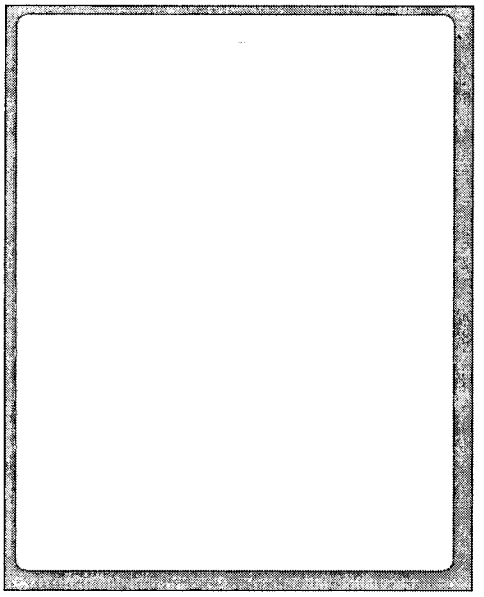

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EMDR

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"I'm an expert in treating chronic infidelity, excessive pornography and many other forms of risky, secret, unethical or compulsive sexual behavior. I'm a highly experienced, effective, and caring therapist who helps individuals and couples to enjoy lives that are fuller, ..."

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Linda S McCall *MSW, LCSW, CHT, HBCE*
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EMDR Therapist Atlanta: Quick tips

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How can I tell if a therapist is right for me?
The therapists in Atlanta, Georgia have broad skills and are able to work with a wide range of issues.

For example, if you're seeking a marriage counselor in Atlanta you'll find that most therapists are trained in marriage counseling or couples counseling in Atlanta and couples therapy. And they welcome families for family counseling in Atlanta or family therapy in Atlanta.

Check out the types of therapists and what to look for to ensure the right fit.

How to find a specialist?
If you're looking for specialist counseling in Atlanta, Georgia, such as a child psychologist or sex therapist, try to refine your search with our left nav bar.

If at first you're unable to find a therapist in Atlanta with the right specialty (e.g. Spanish speaking therapist, child psychiatrist or Christian therapist), try expanding your search area to a wider area (e.g. Georgia) before refining your selection.

If you're looking for EMDR therapy in Atlanta or for an Atlanta EMDR therapist these professionals provide EMDR therapy, eye movement desensitization and reprocessing and EMDR treatment. They include EMDR therapists, EMDR psychologists,

EMDR psychotherapists, and EMDR counselors.

You can also try contacting a therapist or psychologist in Atlanta to ask for a consultation or referral.

What method of therapy is right for me?
When it comes to treatment methods, there's no "right way". A couples counselor or a family counselor may use different treatment methods depending on the one that works best for you. Before choosing a therapist learn about cognitive behavioral therapy, family therapy and psychoanalysis.

How to use my Insurance?
Many therapists accept health insurance. Check to see if your insurance is covered. Feel free to discuss this when you contact the Atlanta therapist. Or read about how insurance for counseling and for therapy usually works.

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EMDR

Eye Movement Desensitization and Reprocessing, is a therapy that helps a client to desensitize stressful and traumatic memories, and reorganize the way associated thoughts are stored in memory. For many, EMDR therapy provides significant relief of anxiety, depression and habitual responses to stress. EMDR was developed in 1987 by a psychologist, Dr Francine Shapiro, for the treatment of post-traumatic stress disorder. Therapists use hand (or flashing light) movements to stimulate side-to-side eye movements. The process sometimes uses other alternating stimuli, such as tapping side-to-side, or tones that alternate from ear to ear. While this is going on, the patient talks about stressful thoughts or traumatic events, and somehow, in the process, they see things in a new light. Some say the results were prompt, and worth months of talk therapy.

EMDR is founded on the premise that each person has both an innate tendency to move toward health and wholeness, and the inner capacity to achieve it. EMDR integrates elements from both psychological theories (e.g. affect, attachment, behavior, bioinformational processing, cognitive, humanistic, family systems, psychodynamic and somatic) and psychotherapies (e.g., body-based, cognitive-behavioral, interpersonal, person-centered, and psychodynamic) into a standardized set of procedures and clinical protocols.

The EMDR therapy model includes the following principles:

1. Each person has a physiological information processing system through which new experiences are processed, stored or released.
2. Information related to life experiences is stored in memory networks that contain related thoughts, images, audio or olfactory memories, emotions, and bodily sensations.
3. Memory networks are organized around the earliest related event.
4. Normal information processing, including activities such as talking with supportive friends, dreaming, problem solving, and healthy communication, lead to adaptive learning and ultimately release from many of the negative effects and consequences of unresolved stress,.
5. Traumatic experiences and persistent unmet interpersonal needs during crucial periods in development are sometimes incompletely processed and become stored in dysfunctional ways.
6. Dysfunctional reactions to stress may arise when memory networks, related to a distressing or traumatic experience, are not fully processed. As a result, troublesome psychiatric symptoms may develop and persist.
7. During an EMDR session, information processing of memory networks is facilitated by specific types of bilateral sensory stimulation, including left-right, visual, audio and tactile stimulation, combined with the other specific procedural steps used in EMDR. These protocols create states of balanced or dual attention to facilitate information processing. In this state the client experiences simultaneously the distressing memory and the present context as observer.
8. The combination of EMDR procedures and bilateral stimulation help make disturbing memory images appear less vivid, and associated feelings become less disturbing.
9. During EMDR therapy, links to positive, helpful information also emerge. EMDR information processing helps to forge new and resourceful associations within and between memory networks.
10. As a result, the client is able to free themselves from many effects of "triggers" that once produced emotional symptoms. The client becomes more resourceful and adaptive in dealing with current life situations.

For more information about EMDR visit http://www.EMDR.com.

EMDR therapy is available at the Medical Center. Call 480-970-0000.

Patients requesting this therapy will be directed to professionals with specific training in these protocols.

Quackwatch Home Page

EMDR Treatment: Less Than Meets the Eye?

Scott O. Lilienfeld, Ph.D.

"Assertions about the utility and validity of psychological techniques . . . must answer to a common-sense demand: 'Show me.' EMDR has thus far failed to convincingly pass the 'Show me" test."

"Quick fixes" for emotional maladies have struck a responsive chord in the general public, as biopsychologist B. L. Beyerstein (1990) has noted. Because these interventions often hold out the hope of alleviating long-standing and previously intractable problems with a minimum of time and effort, they are understandably appealing to both victims of psychological disorders and their would-be healers.

More often than not, however, the initial enthusiasm generated by such treatments has fizzled as soon as their proponents' claims have been subjected to intensive scrutiny. In the case of certain highly touted techiques such as neurolinguistic programming (Druckman and Sweets 1988), subliminal self-help tapes (Moore 1992; Pratkanis 1992), and facilitated communication for autism (Mulick, Jacobson, and Kobe 1993), controlled studies overwhelmingly indicate that early reports of their effectiveness were illusory. In other cases, such as biofeedback for psychosomatic disorders, there is some limited evidence for efficacy, but scant evidence that this efficacy exceeds that of less expensive and less technologically sophisticated treatments (Druckman and Swets 1988). The benefits of biofeedback, for example, are not demonstrably greater than those of relaxation training (Silver and Blanchard 1978).

In the past few years, a novel and highly controversial treatment known as "eye movement desensitization and reprocessing" (EMDR) has burst onto the psychotherapy scene. EMDR has been proclaimed by its advocates as an extremely effective and efficient treatment for Post-Traumatic Stress Disorder (PTSD) and related anxiety disorders. These assertions warrant close examination because PTSD is a chronic and debilitating condition that tends to respond poorly to most interventions.

Although PTSD was not formally recognized as a mental disorder until 1980, descriptions of "shell shock," "battle fatigue," and similar reactions to wartime trauma date back at least to the late nineteenth century (Barlow 1988). PTSD is defined by the American Psychiatric Association (1994, p. 427) as an anxiety disorder resulting from exposure to "an event...that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others." Among the most frequent precipitants of PTSD are military combat, rape, physical assault, motor vehicle accidents, natural disasters, and the witnessing of a murder or accidental death.

The primary symptoms of PTSD fall into three categories: (1) psychological reexperiencing of the traumatic event (e.g. recurrent and disturbing flashbacks and dreams of the event); (2) avoidance of stimuli (e.g. television programs, conversations) that remind the individual of the event; and (3) heightened arousal (e.g., sleep disturbances, increased startle responses).

Although PTSD is difficult to treat, there is accumulating evidence that "exposure treatments," which involve confronting clients with memories and images of the traumatic event, are effective for many cases of PTSD (Frueh, Turner, and Beidel 1995). One of the best known of such interventions is "flooding," in which clients are exposed to trauma-related stimuli for prolonged time periods (often two hours or more) and until their anxiety subsides. Flooding can be performed using either real-life stimuli or visual imagery, although the inability to recreate the actual details of the traumatic scene typically means that the treatment must be conducted imaginally. The mechanisms underlying the success of exposure techniques are still a subject of debate, but many psychologists believe that the effective ingredient in such treatments is "extinction"—the process by which a response dissipates when the stimulus triggering this response is presented without the

original emotional concomitants.

Despite their advantages, exposure treatments for PTSD tend to provoke extreme anxiety and consume much time. Often 20 sessions are required for maximal efficacy (Frueh et al. 1995). As a result, many clients with PTSD are reluctant to undergo such treatments, leading some practitioners to search for less stressful and more time-efficient interventions. Enter EMDR.

Method, Rationale, and Claims

Francine Shapiro, the psychologist who originated EMDR, recalls having fortuitously "discovered" this technique when she found that rapid back-and-forth eye movements reduced her own anxiety (Shapiro 1989b). Shapiro thereafter applied this procedure to her own clients with anxiety disorders and claims to have met with remarkable success. Since the initial published report of its use in 1989, EMDR has skyrocketed in popularity among practitioners. As of mid-1995, approximately 14,000 therapists were licensed to perform EMDR in the United States and other countries (Bower 1995), and this number is growing. EMDR is also attracting international attention. For example, a team of American psychologists recently trained 40 European therapists to administer EMDR to victims of war trauma in Bosnia (Cavaliere 1995).

Although EMDR is alleged to be a complicated technique that requires extensive training (Shapiro 1992), the treatment's key elements can be summarized briefly. Clients are first asked to visualize the traumatic event as vividly as possible. While retaining this image in mind, they are told to supply a statement that epitomizes their reaction to it (e.g., "I am about to die"). Clients are then asked to rate their anxiety on a Subjective Units of Distress (SUDs) scale, which ranges from 0 to 10, with 0 being no anxiety and 10 being extreme terror. In addition, they are told to provide a competing positive statement that epitomizes their desired reaction to the image (e.g., "I can make it"), and to rate their degree of belief in this statement on a 0 to 8 Validity of Cognition scale.

Following these initial steps, clients are asked to visually track the therapist's finger as it sweeps rhythmically from right to left in sets of 12 to 24 strokes, alternated at a speed of two strokes per second. The finger motion is carried out for 12 to 14 seconds in front of the client's eyes. Following each set of 12 to 24 strokes, clients are asked to "blank out" the visual image and inhale deeply, and are then asked for a revised SUDs rating. This process is repeated until clients' SUDs ratings fall to 2 or lower and their Validity of Cognition ratings rise to 6 or higher.

Although EMDR technically requires the use of eye movements, Shapiro (1994a) claimed that she has successfully used the technique with blind clients by substituting auditory tones for movements of the therapist's finger. Recently I attended a presentation on EMDR given by a clinician who reported that, when working with children, he uses alternating hand taps on the knees in liu of back-and-forth finger movements

Since its development, EMDR has been extended to many problems other than PTSD, including phobias, generalized anxiety, paranoid schizophrenia, learning disabilities, eating disorders, substance abuse, and even pathological jealousy (Beere 1992; Marquis 1991; Shapiro 1989b). Moreover Shapiro (1991, p. 135) asserted that "EMDR treatment is equally effective with a variety of 'dysfunctional' emotions such as excessive grief, rage, guilt, etc."

The theoretical rationale for EMDR has not been clearly explicated by either Shapiro or others. Indeed, a recent attempt by Shapiro (1994b, p. 153) to elaborate on EMDR's mechanism of action may mystify even those familiar with the technique: "The system may become unbalanced due to a trauma or through stress engendered during a developmental window, but once appropriately catalyzed and maintained in a dynamic state by EMDR, it transmutes information to a state of therapeutically appropriate resolution."

Shapiro has further conjectured that the eye movement of EMDR are similar to those of rapid eye movement (REM) sleep. Because there is evidence from animal studies that REM sleep is associated with the processing of

memories (Winson 1990), Shapiro has suggested that the eye movements of EMDR may similarly facilitate the processing of partially "blocked" memories. Because there is no evidence that EMDR produces brain changes resembing those occurring during REM sleep, however, the analogy between the eye movements of EMDR and those of REM may be more superficial than real.

EMDR has been hailed by its advocates as a novel treatment that produces much faster and more dramatic improvements than alternative treatments. Shapiro (1989b), for example, asserted that EMDR can successfully treat many or most cases of PTSD in a single 50-minute session, although especially severe cases may require several sessions. Moreover, claims for EMDR's efficacy have not been limited to Shapiro. Psychologist Roger Solomon (1991, cited in Herbert and Mueser 1992) described EMDR as a "powerful tool that rapidly and effectively reduced the emotional impact of traumatic or anxiety evoking situations." Beere (1992, p. 180) reported "spectacular" results after using EMDR on a client with multiple personality disorder.

Similar reports of EMDR's sensational effectiveness have appeared in the media. On July 29, 1994, ABC's "20/20" news-magazine show aired a segment on EMDR. Host Hugh Downs introduced EMDR as "an exciting breakthrough . . . a way for people to free themselves from destructive memories, and it seems to work even in cases where years of conventional therapy have failed." Downs stated, "No one understands exactly why this method succeeds, only that it does." The program featured an excerpt from an interview with Stephen Silver, a psychologist who averred, "It (EMDR) leads immediately to a decrease in nightmares, intrusive memories, and flashbask phenomena. It is one of most powerful tools I've encountered for treating post-traumatic stress" (ABC News 1994).

Although based largely on unsytematic and anecdotal observations, such glowing testimonials merit careful consideration. Are the widespread claims for EMDR's efficacy substantiated by research?

Uncontrolled Case Reports

Many uncontrolled case reports appear to attest to the efficacy of EMDR (e.g., Forbes, Creamer, and Rycroft 1994; Lipke and Botkin 1992; Marquis 1991; Oswalt, Anderson, Hagstron, and Berkowitz 1993; Pellicer 1993; Puk 1991; Spates and Burnett, 1995; Wolpe and Abrams, 1991). All of these case reports utilize a "pre-post design" in which clients are treated with EMDR and subsequently reassessed for indications of improvement. These case reports, although seemingly supportive of EMDR, are for several reasons seriously flawed as persuasive evidence for its effectiveness.

First, case reports, probably even more than large controlled investigations, are susceptible to the "file drawer problem" (Rosenthal 1979) - the selective tendency for negative findings to remain unpublished. It is impossible to determine the extent to which the published cases of EMDR treatment, which are almost all successful, are representative of all cases treated with this procedure.

Second, in virtually all of the published case reports, EMDR was combined with other interventions, such as relaxation training and real life exposure (Acierno, Hersen, Van Hasselt, Trement, and Meuser 1994). As a result, one cannot determine whether the apparent improvement reported in such cases is attributable to EMDR, the ancilary treatments, or both.

Third, and most important, these case reports cannot provide information regarding cause-and-effect relations because they lack a control group of individuals who did not receive EMDR. The ostensible improvement resulting from EMDR in these reports may be due to numerous variables other than EMDR itself (Gastright 1995), such as placebo effects (improvement resulting from the expectation of improvement), spontaneous remission (natural improvement occurring in the absence of treatment), spontaneous remission (natural improvement occurring in the absence of treatment), and regression to the mean (the statistical tendency of extreme scores at an initial testing to become less extreme upon retesting). Consumers of uncontrolled case reports thus must be chary of falling prey to the logical fallacy of post hoc, ergo propter hoc (afer this, therefore because of this): Only in adequately controlled studies can improvement following EMDR treatment be

unequivocably attributed to the treatment itelf.

Controlled Studies

Despite abundant claims for EMDR's efficacy, few controlled outcome studies on EMDR have been conducted. They are of two major types: (1) between-subject designs, in which subjects are randomly assigned to either a treatment or a control group; and (2) within-subject designs, in which subjects serve as their own control.

Between-Subject Designs

In the first controlled investigation of EMDR, Shapiro (1989a) randomly assigned 22 individuals who had experienced a traumatic event to either an EMDR treatment group or an exposure control group. In the latter condition, subjects were provided with imaginal exposure to the trauma, but without the eye movements involved in EMDR. Shapiro reported that after only one session, EMDR subjects exhibited significantly higher Validity of Cognition ratings than subjects in the control group. The control group subjects showed essentially no improvement on either measure.

Superficially, these findings seem to provide impressive support for the effectiveness of EMDR. Even a casual inspection of the study's methodology, however, reveals serious deficiencies in experimental design (Acierno et al. 1994; Herbert and Mueser 1992). First, Shapiro herself conducted both treatments and elicited the SUDs and Validity of Cognition ratings from subjects in both groups. Because Shapiro knew the subjects' treatment condition, her findings are potentially attributable to the well-documented experimenter expectancy effect (Rosenthal 1967)—the tendency for researchers to unintentionally bias the results of their investigations in accord with their hypotheses. Specifically, Shapiro might have unwittingly delivered treatment more effectively or convincingly to the EMDR group, or subtly influenced subjects in this group to report greater improvement. Second, the cessation of traumatic imagery was contingent on low SUDs ratings in the EMDR group, but not in the imaginal exposure gorup (Lohr, Kleinknecht, Conly, Cerro, Schmidt, and Sonntag 1992). It is therefore possible that subjects in the EMDR group reported low SUDs ratings in order to terminate this aversive imagery. Moreover, the total amount of exposure in the two groups may have differed (Lohr et al. 1992). These methodological shortcomings render the results of Shapiro's study (Shapiro 1989a) virtually uninterpretable.

Since this initial report, a number of investigators have attempted to replicate Shapiro's methodology of comparing EMDR with an imaginal exposure control condition for clients with PTSD or other anxiety disorders. Several of these researchers used a "dismantling" design in which EMDR was compared with an otherwise identical procedure minus the eye movements; in this design certain components of the treatment that are purported to be effective (in this case, eye movements) are removed from the full treatment package to determine if their omission decreases therapeutic effectiveness. Renfrey and Spates (1994), for example, compared EMDR with an imaginal exposure condition in which subjects stared at a stationary object.

In virtually all of these investigations, EMDR was not consistently more effective than the exposure control condition, although both conditions appeared to produce improvements on some measures. In one study (Boudewyns et al 1993), EMDR was found to be more effective than the control condition, but only when within-session SUDs ratings were used. In this investigation, however, as in Shapiro's study (1989a), cessation of the traumatic scene was contingent on low SUDs ratings in the EMDR condition only, so this finding may again reflect the subjects' desire to terminate exposure to unpleasant imagery. Interestingly, SUDs ratings obtained outside of sessions in response to audiotaped depections of clients' traumatic experiences indicated no differences between conditions. Moreover, physiological reactions (e.g. heart rate increases) to these depictions showed no improvement in either condition.

Sanderson and Carpenter (1992), who administered EMDR and imaginal exposure in counterbalanced order, found that EMDR and imaginal exposure yielded equivalent improvements (using SUDs ratings taken outside of treatment session) but that EMDR was effective only when preceded by imaginal exposure. Rengrey and Spares (1994, p. 238) reported that EMDR was no more effective than a control proceudre involving fixed

visual attention, leading them to conclude that "eye movements are not an essential component of the intervention."

Only one published study has directly compared EMDR with a no-treatment control group. Jensen (1994) randomly assigned Vietnam veterans with PTSD to either an EMDR group or a control group that was promised delayed treatment. EMDR produced lower within-session SUDs ratings compared with the control condition, but did not differ from the control session in its effect on PTSD symptoms. In fact, the level of interviewer-rated PTSD symptoms increased in the EMDR group following treatment.

Within-Subject Designs

Three teams of investigators have used within-subject designs to examine the efficacy of EMDR. Acierno, Tremont, Last, and Montgomery (1994) treated a client with phobias of dead bodies and the dark using both EMDR and "Eye-Focus Desensitization," the latter identical to EMDR except the therapist's finger remained stationary. In the case of the client's fear of dead bodies, EMDR was administred first; in the case of the cleint's fear of the dark, Eye-Focus Desensitization was administered first. EMDR showed little or no advantage over the control procedure on self-report, physiological, or behavioral measures, the last of which involved asssessments of the client's willingness to approach feared stimuli.

In contrast, Montgomery and Ayllon (1994a) reported that EMDR yielded significant decreases in SUDs levels and client reports of PTSD symptoms, whereas a control procedure consisting of EMDR minus eye movements did not. These two procedures were not, however, administered in counterbalanced order; the control procedure was always presented first. Consequently, the improvements following EMDR may have been due to a delayed effect of the control procedure. Alternatively they might have resulted from the cumulative effect of the exposure provided by both procedures, regression to the mean effects, or to other factors unrelated to EMDR. EMDR did not produce improvements on physiological indices (heart rate and systolic blood pressure).

Finally, Montgomery and Ayllon (1994b) treated a client with PTSD who had experienced two distinct traumatic events (a car accident and an assault at knifepoint). EMDR was applied separately to the memories of each event. EMDR appeared to show beneficial effects on subjective distress, although the degree of improvement was much less than that reported by Shapiro (1989a). Because EMDR was not compared with a control procedure involving imaginal exposure, its unique effects cannot be ascertained.

The Verdict

Because of the paucity of adequately controlled studies on EMDR, it would be premature to proffer any definitive conclusions regarding its effectiveness. Nevertheless, the following assertions are warranted on the basis of the evidence.

1. Although a multitude of uncontrolled case reports seemingly demonstrate that EMDR produces high success rates, these reports are open to numerous alternative explanations and thus do not provide compelling evidence for EMDR's effectiveness.
2. Controlled studies provide mixed support for the efficacy of EMDR. Most of the evidence for EMDR's effectiveness derives from clients' within-session ratings (which in some cases may be influenced by the desire to terminate esposure), but not from more objective measures of improvement. There is no evidence that EMDR eliminates many or most of the symptoms of PTSD in one session.
3. There is no convincing evidence that EMDR is more effective for post-traumatic anxiety than standard exposure treatments. If EMDR works at all, it may be because it contains an exposure component (Steketee and Goldstein 1994). The proponents of EMDR have yet to demonstrate that EMDR represents a new advance in the treatment of anxiety disorders, or that the eye movements purportedly critical to this technique constitute anything more than pseudoscientific window dressing.

Thus, the most justified conclusion concerning EMDR's effectiveness is: Not proven. Nonetheless, many proponents of EMDR remain convinced that the treatment utility of EMDR will ultimately be demonstrated. Shapiro (1992, p. 114), for example, opined, "When the efficacy of EMDR is fully established, I would like to

see it taught in the universities. When that happens, three-hour workshops on specialized applications of EMDR will undoubtedly be offered . . ." These statements, which were made after approximately 1,200 licensed therapists had already received formal training in EMDR (Shapiro 1992), raise troubling questions. Should not the efficacy of a therapeutic technique be established before it is taught to clinicians for the express purpose of administering it to their clients? Moreover, does not the spirit of open scientific inquiry demand that the proponents of a novel technique remain agnostic regarding its efficacy pending appropriate data, and that the two sentences quoted above should therefore begin with "if" rather than "when?"

Concluding Comments

Dawes (1994) has argued that assertions about the utility and validity of psychological techniques, like assertions in all areas of science, must answer to a commonsense demand: "Show me." EMDR has thus far failed to convincingly pass the "Show me" test. Claims for its efficacy have greatly outstripped its empirical support. Although Shapiro has suggested that "there is more to EMDR than meets the eye" (1994b, p. 155), a skeptical consumer of the literature might well be tempted to draw the opposite conclusion.

Moreover, because EMDR has not been clearly shown to be beneficial for the condition for which it was originally developed, namely PTSD, its extension as a treatment for schizophrenia, eating disorders, and other conditions is even more premature and ethically problematic. Furthermore, both scientific and logical considerations dictate that the developers of a treatment should specify the boundary conditions under which this technique is and is not effective. Because EMDR purportedly facilitates the processing of traumatic memories, one would not expect it to be useful for conditions (e.g. schizophrenia) in which severe emotional trauma has not been found to play a major causal role.

Indeed, claims that EMDR is helpful for such conditions (Marquis 1991) actually call into question the presumed mechanisms underlying EMDR's mode of action. So far, however, the proponents of EMDR have made little or no effort to delineate the boundary conditions of their method's effectiveness. Moreover, the assertion taht EMDR works equally well with auditory tones and hand-taps as with eye movements (Shapiro 1994a) runs counter to Shapiro's theoretical conjectures regarding EMDR's commonalities with REM sleep.

Although further research on EMDR is warranted, such research will likely be impeded by the prohibitions laced on the open distribution of EMDR training materials (Acierno et al. 1994). For example, participants in EMDR workshops must agree not to audiotape any portion of the workshop, train others in the technique without formal approval, or disseminate EMDR training information to colleagues (Rosen 1993). It seems difficult to quarrel with Herbert and Meuser's (1992, p. 173) contention that although "this procedure is justified to maintain 'quality contro,' such a restriction of information runs counter to the principle of open and free exchange of ideas among scientists and professionals."

Because of the limited number of controlled studies on EMDR, both practitioners and scientists should remain open to the possibility of its effectiveness. Nevertheless, the standard of proof required to use a new procedure clinically should be considerably higher than the standard of proof required to conduct research on its efficacy. This is particularly true in the case of such conditions as PTSD, for which existing treatments have already been shown to be effective. The continued widespread use of EMDR for therapeutic purposes in the absence of adequate evidence can be seen as only another example of the human mind's willingness to sacrifice critical thinking for wishful thinking.

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Eye movement desensitization and reprocessing

From Wikipedia, the free encyclopedia

Eye movement desensitization and reprocessing (EMDR) is a form of psychotherapy that was developed to resolve symptoms resulting from disturbing and unresolved life experiences. It uses a structured approach to address past, present, and future aspects of disturbing memories. The approach was developed by Francine Shapiro[1][2] to resolve the development of trauma-related disorders as resulting from exposure to a traumatic or distressing event, such as rape or military combat. Clinical trials have been conducted to assess EMDR's efficacy in the treatment of post-traumatic stress disorder (PTSD). Although some clinicians may use EMDR for other problems, its research support is primarily for disorders stemming from distressing life experiences.[3]

Contents

Approach

EMDR uses a structured eight-phase approach and addresses the past, present, and future aspects of the dysfunctionally stored memory. During the processing phases of EMDR, the client attends to the disturbing memory in multiple brief sets of about 15–30 seconds, while simultaneously focusing on the dual attention stimulus (e.g., therapist-directed lateral eye movement, alternate hand-tapping, or bilateral auditory tones). Following each set of such dual attention, the client is asked what associative information was elicited during the procedure. This new material usually becomes the focus of the next set. This process of alternating dual attention and personal association is repeated many times during the session.

EMDR integrates elements of effective psychodynamic, imaginal exposure, cognitive therapy, interpersonal, experiential, physiological and somatic therapies. It also uses the unique element of bilateral stimulation (e.g. eye movements, tones, or tapping). According to Francine Shapiro's theory,[1] when a traumatic or distressing experience occurs, it may overwhelm usual ways of coping and the memory of the event is inadequately processed; the memory is dysfunctionally stored in an isolated memory network.

Although EMDR is established as an evidence-based treatment for PTSD[4][5][6][7][8] there are two main perspectives on EMDR therapy. First, Shapiro[1] proposed that although a number of different processes underlie EMDR, the eye movements add to the therapy's effectiveness by evoking neurological and physiological changes that may aid in the processing of the trauma memories being treated. The other perspective is that the eye movements are an epiphenomenon, unnecessary, and that EMDR is simply a form of

desensitization.[9]

When this memory network is activated, the individual may re-experience aspects of the original event, often resulting in inappropriate overreactions. This explains why people who have experienced or witnessed a traumatic incident may have recurring sensory flashbacks, thoughts, beliefs, or dreams. An unprocessed memory of a traumatic event can retain high levels of sensory and emotional intensity, even though many years may have passed.

The theory is that EMDR works directly with memory networks and enhances information processing by forging associations between the distressing memory and more adaptive information contained in other semantic memory networks. It is thought that the distressing memory is transformed when new connections are forged with more positive and realistic information. This results in a transformation of the emotional, sensory, and cognitive components of the memory so that, when it is accessed, the individual is no longer distressed. Instead he/she recalls the incident with a new perspective, new insight, resolution of the cognitive distortions, elimination of emotional distress, and relief of related physiological arousal.

When the distressing or traumatic event is an isolated, single incident, approximately three sessions are necessary for comprehensive treatment. When multiple traumatic events contribute to a health problem—such as physical, sexual, or emotional abuse, parental neglect, severe illness, accident, injury, or health-related trauma that result in chronic impairment to health and well-being, or combat trauma, the time to heal may be longer,[10] and complex, multiple trauma may require many more sessions for the treatment to be complete and robust.

Therapy process

The therapy process and procedures are according to Shapiro (2001)[1]

Phase I
: In the first sessions, the patient's history and an overall treatment plan are discussed. During this process the therapist identifies and clarifies potential targets for EMDR. Target refers to a disturbing issue, event, feeling, or memory for use as an initial focus for EMDR. Maladaptive beliefs are also identified.

Phase II
: Before beginning EMDR for the first time, it is recommended that the client identify a safe place, an image or memory that elicits comfortable feelings and a positive sense of self. This safe place can be used later to bring closure to an incomplete session or to help a client tolerate a particularly upsetting session.

Phase III
: In developing a target for EMDR, prior to beginning the eye movement, a snapshot image is identified that represents the target and the disturbance associated with it. Using that image is a way to help the client focus on the target, a negative cognition (NC) is identified – a negative statement about the self that feels especially true when the client focuses on the target image. A positive cognition (PC) is also identified – a positive self-statement that is preferable to the negative cognition.

Phase IV
: The therapist asks the patient to focus simultaneously on the image, the negative cognition, and the disturbing emotion or body sensation. Then the therapist usually asks the client to follow a moving object with his or her eyes; the object moves alternately from side to side so that the client's eyes also move back and forth. After a set of eye movements, the client is asked to report briefly on what has come up; this may be a thought, a feeling, a physical sensation, an image, a memory, or a change in any one of the above. In the initial instructions to the client, the therapist asks him or her to focus on this thought, and begins a new set of eye movements. Under certain conditions, however, the therapist directs the client to focus on the original target memory or on some other image, thought, feeling, fantasy, physical sensation, or memory. From time to time the therapist may query the client about her or his current level of distress. The desensitization phase ends when the SUDS (Subjective Units of Disturbance Scale) has reached 0 or 1.

Phase V
: The "Installation Phase": the therapist asks the client about the positive cognition, if it's still valid. After Phase IV, the view of the client on the event/ the initial snapshot image may have changed dramatically. Another PC may be needed. Then the client is asked to "hold together" the snapshot and the (new) PC. Also the therapist asks, "How valid does the PC feel, on a scale from 1 to 7?" New sets of eye movement are issued.

Phase VI
: The body scan: the therapist asks if anywhere in the client's body any pain, stress or discomfort is felt. If so, the client is asked to concentrate on the sore knee or whatever may arise and new sets are issued.

Phase VII
: Debriefing: the therapist gives appropriate info and support.

Phase VIII
: Re-evaluation: At the beginning of the next session, the client reviews the week, discussing any new sensations or experiences. The level of disturbance arising from the experiences targeted in the previous session is assessed. An objective of this phase is to ensure the processing of all relevant historical events.

EMDR also uses a three-pronged approach, to address past, present and future aspects of the targeted memory.

Mechanism

The theory underlying EMDR treatment is that it works by helping the sufferer process distressing memories more fully which reduces the distress. EMDR is based on a theoretical information processing model which posits that symptoms arise when events are inadequately processed, and can be eradicated when the memory is fully processed. It is an integrative therapy, synthesizing elements of many traditional psychological orientations, such as psychodynamic, cognitive behavioral, experiential, physiological, and interpersonal therapies.

EMDR's unique aspect is an unusual component of bilateral stimulation of the brain, such as eye movement, bilateral sound, or bilateral tactile stimulation coupled with cognitions, visualized images and body sensation. EMDR also utilizes dual attention awareness to allow the individual to vacillate between the traumatic material and the safety of the present moment. This can help prevent retraumatization from exposure to the disturbing memory.

There is no definitive explanation as to how EMDR may work. There is some empirical support for each of three different explanations regarding how an external stimulus such as eye movement could facilitate the processing of traumatic memories.

Empirical evidence and comparison

A recent review rated EMDR as an effective method for the treatment of PTSD, and the International Society of Stress Studies practice guidelines categorized EMDR as an evidence-based level A treatment for PTSD in adults.[11][8] A number of international guidelines include EMDR as a recommended treatment for trauma.[5][6][7][8]

Research on the application of EMDR therapy continues, and several meta-analyses have been performed to further evaluate its efficacy in the treatment of PTSD. In one meta-analysis of PTSD, EMDR was reported to be as effective as exposure therapy and SSRIs.[12] Two separate meta-analyses suggested that traditional exposure therapy and EMDR have equivalent effects both immediately after treatment and at follow-up.[13][14] A 2007 meta-analysis of 38 randomized controlled trials for PTSD treatment suggested that the first-line psychological treatment for PTSD should be Trauma-Focused CBT (Cognitive Behavioral Therapy) or EMDR.[15] A review of rape treatment outcomes concluded that EMDR had some efficacy.[16] Another meta-analysis concluded that

all "bona fide" treatments were equally effective, but there was some debate regarding the study's selection of which treatments were "bona fide".[17] A comparative review concluded EMDR to be of similar efficacy to other exposure therapies and more effective than SSRIs, problem-centred therapy, or treatment as usual.[18]

Other applications

Although controlled research has concentrated on the application of EMDR to PTSD, a number of studies have investigated EMDR's efficacy with other anxiety disorders as well as numerous reports of diverse clinical applications.

Depression

EMDR can work on a multitude of problems that are less complex than PTSD. One of these is uncomplicated depression. The EMDR Casebook by Philip Manfield, has documented several case studies in which EMDR was used. In the case about uncomplicated depression, Manfield was able to help his client, George, resolve several childhood issues that have plagued his adult life. Moreover, EMDR can work for postpartum depression. By having the client target a distinctive memory and work through it with a series of eye movements, the client is then able to achieve a positive cognition.[19]

In children

It has been used in the treatment of children who have experienced trauma and complex trauma.[20][21]

It is often cited as a component in the treatment of complex post-traumatic stress disorder,[22] emotional dysregulation, and in the treatment of children exposed to chronic early maltreatment that is related to attachment disorder.

For personal improvement

EMDR has also been used in performance and creativity enhancement with athletes and stage performers.[23]

Controversy over mechanisms and effectiveness

The working mechanisms that underlie the effectiveness of EMDR, and whether the eye movement component in EMDR contributes to its clinical effectiveness are still points of uncertainty and contentious debate.[24][25][26]

EMDR has generated a great deal of controversy since its inception in 1989. Critics of EMDR argue that the eye movements do not play a central role, that the mechanisms of eye movements are speculative, and that the theory leading to the practice is not falsifiable and therefore not amenable to scientific enquiry.[27]

Although one meta-analysis concluded that EMDR is not as effective, or as long lasting, as traditional exposure therapy,[28] several other researchers using meta-analysis have found EMDR to be at least equivalent in effect size to specific exposure therapies.[12][13][14][15]

Exposure

Despite the treatment procedures being quite different between EMDR and traditional exposure therapy, some authors[5][29] continue to argue that the main effective component in EMDR is exposure.

The exposure that occurs in EMDR should, according to the assumptions of emotional processing theory,[30] sensitise rather than desensitise and decrease the fear and distress associated with traumatic memories. However, EMDR is effective, therefore processes other than imaginal exposure must play a role in the effectiveness of EMDR in the treatment of PTSD.

Eye movements

An early critical review and meta-analysis that looked at the contribution of eye movement to treatment effectiveness in EMDR concluded that eye movement is not necessary to the treatment effect.[9][31] Salkovskis (2002) reported that the eye movement is irrelevant and that the effectiveness of the procedure is solely due to its having properties similar to cognitive behavioral therapies, such as desensitization and exposure.[32]

Effect of eye movement on memory, cognitive processes, and physiology

Although a wide range of researchers have proposed various models and theories to explain the effect of eye movement, and the possible role that eye movement may play in the process of EMDR, to date, no single model or theory exists that can explain all of the above mentioned findings. Further research is therefore required in this area.

See also

- Neuroplasticity

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Categories: Anxiety disorder treatment | Counseling | Clinical psychology | Mental health | Psychiatric treatments | Psychotherapy

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What Is EMDR?

Eye Movement Desensitization and Reprocessing, or EMDR, is a powerful new psychotherapy technique which has been very successful in helping people who suffer from trauma, anxiety, panic, disturbing memories, post traumatic stress and many other emotional problems. Until recently, these conditions were difficult and time-consuming to treat. EMDR is considered a breakthrough therapy because of its simplicity and the fact that it can bring quick and lasting relief for most types of emotional distress.

EMDR is the most effective and rapid method for healing PTSD (Post Traumatic Stress Disorder) as shown by extensive scientific research studies.

The EMDR therapy uses bilateral stimulation, right/left eye movement, or tactile stimulation, which repeatly activates the opposite sides of the brain, releasing emotional experiences that are "trapped" in the nervous system. This assists the neurophysiological system, the basis of the mind/body connection, to free itself of blockages and reconnect itself.

As troubling images and feelings are processed by the brain via the eye-movement patterns of EMDR, resolution of the issues and a more peaceful state are achieved.

How Does It Work?

The therapist works gently with the client and asks him/her to revisit the traumatic moment or incident, recalling feelings surrounding the experience, as well as any negative thoughts, feelings and memories. The therapist then holds her fingers about eighteen inches from the clients face and begins to move them back and forth like a windshield wiper. The client tracks the movements as if watching ping pong. The more intensely the client focuses on the memory, the easier it becomes for the memory to come to life. As quick and vibrant images arise during the therapy session, they are processed by the eye movements, resulting in painful feelings being exchanged for more peaceful, loving and resolved feelings.

What problems are helped by EMDR?

The studies to date show a high degree of effectiveness with the following conditions:

- loss of a loved one
- injury of a loved one
- car accident
- fire
- work accident
- assault
- robbery
- rape
- natural disaster
- injury
- illness
- witness to violence
- childhood abuse
- victims of violent crimes
- performance and test anxiety
- trauma
- depression
- anxiety or panic
- phobias
- fears
- childhood trauma
- physical abuse
- sexual abuse
- post traumatic stress
- bad temper
- overwhelming fears
- panic attacks
- low self-esteem
- relationship problems
- brooding or worrying
- trouble sleeping

The EMDR technique is most effective when used in conjunction with other traditional methods of therapy in treating these and many other emotional disorders.

EMDR therapy can help clients replace their anxiety and fear with positive images, emotions and thoughts.

What are the Symptoms that can be helped by EMDR?

* High anxiety and lack of motivation
* Depression
* Memories of a traumatic experience
* Fear of being alone
* Unrealistic feelings of guilt and shame
* Fear of being alone
* Difficulty in trusting others
* Relationship problems

What is the History of EMDR?

Since the initial medical study in 1989 positive therapeutic results with EMDR have been reported with the following populations:

* People who have witnessed or been a victim to a disaster (rape, accidents, earth quakes, fires, murder, gang related violence)
* Clients suffering from PTSD (post traumatic stress disorder)
* Suffers of panic disorders and anxiety attacks
* Suffers of phobias
* Chemically dependent clients
* Persons exposed to excess loss (loss by death, divorce, loss of a house by fire)
* Crime victims and police officers who were once overcome with violent memories
* Accident or burn victims

Although a fairly new therapeutic technique, EMDR is meeting with much success all across the county. EMDR is a natural process. The client and the therapist become partners on a journey to help move traumatic and blocked energy. Together they work to transcend and free up the energy, so the client can return to their natural grounded state of being. The goal of this work is to help the client heal, so they can return to their life in peace.

How do I know if EMDR is right for me?

There are a number factors to consider when evaluating the appropriateness of EMDR therapy for a client's particular situation and history. During your initial consultation with a trained EMDR therapist, all the relevant factors will be discussed in full to help you both come to a decision to move forward with EMDR.

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EMDR

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Clinical Update February 2009

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EMDR is internationally regarded as an empirically supported treatment for traumatic memories. It is an integrative, client-centered psychotherapy approach that is guided by the Adaptive Information Processing model. EMDR emphasizes the brain's information processing system and memories of disturbing experiences as the bases of those pathologies not caused by organic deficit or injury.

EMDR Recap:

- EMDR has been designated as an effective treatment of trauma in numerous international treatment guidelines, including those of the American Psychiatric Association.
- Randomized controlled research indicates that most clients who have experienced a single traumatic event can be successfully treated with EMDR in three 90-minute reprocessing sessions.
- Studies suggest that the eye movement used in EMDR produces an increase in parasympathetic activity and a decrease in psychophysiological arousal.
- Theory and research reports indicate that EMDR effects may be related to those that occur in REM sleep.
- Unlike exposure therapies, with EMDR it is not necessary to force the client to speak in detail about the memory nor to do hours of daily homework.
- EMDR treatment indicates that dysfunctional emotions, physical sensations, and perspectives are manifestations of the stored memories that can be eliminated with adequate processing.
- EMDR can be used to treat a wide range of clinical complaints that are caused or exacerbated by experiential contributors.
- EMDR treatment indicates that what may seem to be organic life-long depression may actually be caused by physiologically stored memories from childhood that have remained unprocessed.
- During the EMDR processing sessions, clients understand the unconscious associations they've been making and often experience a rapid and simultaneous transmutation from dysfunctional perception, affect, and physical arousal to healthy perceptual, emotional and physical states.

- EMDR can be used for family therapy, as well as individual therapy, in that it addresses the earlier dysfunctionally stored memories that are feeding the destructive interactions and behaviors.
- EMDR can be used to address deficits in maternal bonding, as well as childhood attachment issues.
- EMDR has also been found to be successful in treating somatoform disorders such as chronic pain, Body Dysmorphic Disorder, and in decreasing or completely eliminating phantom limb pain.
- EMDR uses an 8-phase approach to address the past experiences that have set the groundwork for dysfunction, present situations that trigger disturbance, and future templates to address skill and developmental deficits.

The EMDR course will teach psychotherapists to:

- Define the phases of treatment that comprise EMDR's integrative psychotherapy approach.
- Summarize the Adaptive Information Processing model that guides EMDR treatment and case conceptualization.
- List the types of cases amenable to EMDR treatment.
- Describe the kinds of cognitive, emotional, somatic, and behavioral changes attainable with EMDR.

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EMDR

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Psychological and Physiological
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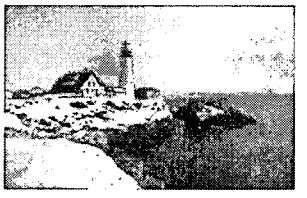

Traumatic stress is found in many competent, healthy, strong, good people. No one can completely protect themselves from traumatic experiences. Many people have long-lasting problems following exposure to trauma. Up to 8% of persons will have PTSD at some time in their lives. People who react to traumas are not going crazy. ***What is happening to them is part of a set of common symptoms and problems that are connected with being in a traumatic situation, and thus, is a normal reaction to abnormal events and experiences.*** Having symptoms after a traumatic event is NOT a sign of personal weakness. Given exposure to a trauma that is bad enough, probably all people would develop PTSD. By understanding trauma symptoms better, a person can become less fearful of them and better able to manage them. By recognizing the effects of trauma and knowing more about symptoms, a person will be better able to decide about getting treatment.

DID-PTSD-EMDR

Dissociative Identity Disorder (DID)

"The essential feature of Dissociative identity Disorder is the presence of two or more distinct identities or personality states

EMDR PTSD Dissociation

Life Cycle Journeys

EMDR and Depression

Title: Treatment of PTSD: Stress Inoculation Training with Prolonged Exposure compared to EMDR.
Author(s): Lee, Christopher , Sir Charles Gairdner Hosp, QEII Medical Ctr, Perth, Australia;
Gavriel, Helen, HMAS Stirling, Royal Australian Navy, Australia;
Drummond, Peter , Murdoch U, School of Psychology, Perth, Australia;
Richards, Jeff, U Ballarat, Ballarat, Australia;
Greenwald, Ricky , Mount Sinai School of Medicine, New York, NY, US
Address: Lee, Christopher, 88 Palmerston St., Mosman Park, WAU, Australia, 6012, chlee@central.murdoch.edu.au
Source: Journal of Clinical Psychology , Vol 58 (9), Sep 2002. pp. 1071-1089.
Publisher: US: John Wiley & Sons.
Abstract: The effectiveness of Stress Inoculation Training with Prolonged Exposure (SITPE) was compared to Eye Movement Desensitization and Reprocessing (EMDR). 24 participants (mean age 35.3 yrs) who had a diagnosis of Post Traumatic Stress Disorder (PTSD) were randomly assigned to one of the treatment conditions. Participants were also their own wait-list control. Outcome measures included self-report and observer-rated measures of PTSD, and self-report measures of depression. On global PTSD measures, there were no significant differences between the treatments at the end of therapy. However on the subscale measures of the degree of intrusion symptoms, EMDR did significantly better than SITPE. At follow-up EMDR was found to lead to greater gains on all measures.

(Criterion A) that recurrently take control of behavior (Criterion B). There is an inability to recall important personal information, the extent of which is too great to be explained by ordinary forgetfulness (Criterion C). The disturbance is not due tot eh direct physiological effects of a substance or a general medical condition (Condition D.). In children, the symptoms cannot be attributed to imaginary playmates or other fantasy play.

Dissociative Identity Disorder reflects a failure to integrate various aspects of identity, memory, and consciousness. Each personality state may be experienced as if it has a distinct personal history, self-image, and identity, including a separate name. Usually there is a primary identity that carries the individual's given name and is passive, dependent, guilty, and depressed. The alternate identities frequently have different names and characteristics that contrast with the primary identity (e.g., are hostile, controlling, and self-destructive). Particular identities may emerge in specific circumstances and may differ in reported age and gender, vocabulary, general knowledge, or predominant affect. Alternate identities are experienced as taking control in sequence, ore at the expense of the other, and may deny knowledge of one another, be critical of one another, or appear to be in open conflict. Occasionally, one or

Title: Eye movement desensitization and reprocessing: Efficacy with residential latency-age children.
Author(s): Eckley, Terri Lynn , Alliant International U., US
Source: Dissertation Abstracts International: Section B: The Sciences & Engineering , Vol 63(2-B), Aug 2002. pp. 1021.
Publisher: Transaction Periodicals Consortium, Rutgers University.
Abstract: This archival study examined the efficacy of EMDR with residential latency-age children. Participants in the study were the records of five children who completed a 10-week EMDR treatment protocol, and four children who were in a control group. Treatment included art therapy, play therapy, drama therapy, and talk therapy. EMDR was included as a component of the overall treatment for the experimental group. Pre- and post-measures were assessed using the Behavior Assessment Scale for Children (BASC) and the Trauma Symptom Checklist for Children (TSCC). Three versions of the BASC were used in this study: the Parent Rating Scale (PRS), the Teacher Rating Scale (TRS), and the Self Report of Personality (SRP). Paired-sample t tests demonstrated significant differences on the BASC-SRP and the TSCC for the experimental group at pre- and post-measures. For the BASC-SRP, the children in the experimental group endorsed significantly fewer items for Atypicality, Locus of Control, Social Stress, and Anxiety at the conclusion of the study as compared to initial results. For the experimental group, three of the six scales on the TSCC were significantly lower at the end of the study than at the beginning of the study. The children endorsed significantly fewer symptoms of PTSD, Depression, and Dissociation at the end of treatment as compared to the beginning of treatment. Because of the numerous limitations of this study, generalizability is inevitably limited. However, the outcome of this research indicates that EMDR can be effective to reduce overall symptomology of severely traumatized children.

Title: The use of eye movement desensitization

more powerful identities allocate time to the others. Aggressive or hostile identities may at times interrupt activities or place the others in uncomfortable situations.

Individuals with this disorder experience frequent gaps in memory for personal history, both remote and recent. The amnesia is frequently asymmetrical. The more passive identities tend to have more constricted memories, whereas the more hostile, controlling, or "protector" identities have more complete memories. An identity that is not in control may nonetheless gain access to consciousness by producing auditory or visual hallucinations (e.g., a voice giving instructions). Evidence of amnesia may be uncovered by reports from others who have witnessed behavior that is disavowed by the individual or by the individual's own discoveries (e.g., finding items of clothing at home that the individual cannot remember having bought). There may be loss of memory not only for recurrent periods of time, but also an overall loss of biographical memory for some extended period of childhood, adolescence, or even adulthood. Transitions among identities are often triggered by psychosocial stress. The time required to switch from one identity to another is usually a matter of seconds, but, less frequently, may b gradual. Behavior that may be frequently

and reprocessing (EMDR)
within a multi-modal treatment program for child victims of
extrafamilial sexual abuse.
Author(s): Bermudez, Jose Simon , Carlos Albizu U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 63(6-B), Jan 2002. pp. 3000.
Publisher: US: Univ Microfilms International.
Abstract: Sexual abuse has created multiple short and long term
problems for many individuals in society today. It often occurs in
childhood and the scars that are left can be permanent. Statistically,
it occurs with far greater frequency than should be tolerated. However,
it is frequently unreported and can be difficult to detect in a child
that experiences this form of trauma. There is a significant need to
help these children that have been victims of this crime. Extrafamilial
sexual abuse in particular appears to occur with greater frequency than
intrafamilial sexual abuse. Studies show that it has lasting effects on
children. Two of the most common and consistent symptoms seen with these
children are post-traumatic stress disorder (PTSD) and sexualized
behavior. Other symptoms that have been found with these children
include: depression, anxiety, fear, and difficulty managing anger.
Although there have been many program designs implemented for child
sexual abuse victims, most do not properly assess the level of
improvement through objective measures that show that the treatment was
responsible for the observed change and not some other variable. Many
different forms of treatment have been used to treat sexual abuse
victims, such as different forms of traditional individual therapies,
family therapy, group therapy, drama therapy, and art therapy. One
innovative psychotherapeutic technique that has been used recently with
these types of clients and those who have experienced other types of
traumatic events is Eye Movement Desensitization and Reprocessing
(EMDR). EMDR is a relatively new form of treatment developed in 1987 by
Francine Shapiro. There have been controlled research studies that have
shown the efficacy of this technique. Although

associated with identity switches include rapid blinking, facial changes, changes in voice or demeanor, or disruption in the individual's train of thoughts. The number of identities reported ranges from 2 to more than 100. Half of reported cases include the individuals with 10 or fewer identities."

Diagnostic and Statistical Manual of Mental Disorders. 2000. 4th ed. Washington, D.C.: American Psychiatric Association.

PTSD, DID, and EMDR

Posttraumatic Stress Disorder

"The essential feature of Posttraumatic Stress Disorder us the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criteria A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic

there are some researchers who are skeptical of the use of this technique and challenge its effectiveness, studies have nonetheless shown that it is an effective form of brief therapy with long-term effects. This proposed treatment program would be developed for children, aged 6-12 years, who have been victims of extrafamilial sexual abuse. It is designed to be short term, lasting 4 months, and EMDR will be utilized as the primary psychotherapeutic tool to assist the children in reprocessing their traumatic experience. Mental health services that would be provided include individual therapy consisting primarily of EMDR, group therapy for the child and the parents or caretakers provided separately, and family therapy that would include the parents, child, and siblings if deemed necessary. The children admitted to the program would meet criteria for a diagnosis of PTSD. They would also be given psychological measures in order to establish a baseline in terms of current symptoms such as depression and anxiety. The same measures would be administered again at the completion of treatment allowing for the measurement of any improvements. It is expected that children who complete the program would show a significant reduction or elimination of PTSD symptoms. This can be done more effectively by treating the family as a unit in dealing with such a traumatic experience. It is believed that this form of treatment would provide a valuable service to the community and further our understanding regarding the efficacy of EMDR.

Title: Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: A field study.
Author(s): Chemtob, Claude M. , Dept of Veterans Affairs, National Ctr for PTSD, Pacific Islands Div, Honolulu, HI, US;Nakashima, Joanne; Carlson, John G.
Address: Chemtob, Claude M., Dept of Veterans Affairs, National Ctr for PTSD, Pacific Islands Div, 1132 Bishop St, Suite 307, Honolulu, HI, US, 96813
Source: Journal of Clinical Psychology , Vol 58 (1), Jan 2002.

symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced y a family member or a close friend; learning about the sudden, unexpected

pp. 99-112.
Publisher: US: John Wiley & Sons.
Abstract: Evaluated the effectiveness of a brief intervention for
disaster-related posttraumatic stress disorder (PTSD). At 1-yr follow-up
of a prior intervention for disaster-related symptoms, some previously
treated children were still suffering significant trauma symptoms. Using
a randomized lagged-groups design, 3 sessions of Eye Movement
Desensitization and Reprocessing (EMDR) treatment were provided to 32 of
these children (ages 6-12 yrs) who met clinical criteria for PTSD. The
Children's Reaction Inventory (CRI) was the primary measure of the
treatment's effect on PTSD symptoms. Associated symptoms were measured
using the Revised Children's Manifest Anxiety Scale (RCMAS) and the
Children's Depression Inventory (CDI). Treatment resulted in substantial
reductions in both groups' CRI scores and in significant reductions in
RCMAS and CD1 scores. Gains were maintained at 6-mo follow-up. Health
visits to the school nurse were significantly reduced following
treatment. Psychosocial intervention appears useful for children
suffering disaster-related PTSID. Conducting controlled studies of
children's treatment in the postdisaster environment appears feasible.

Title: Comparison for two treatments for traumatic stress: A
community-based study of EMDR and prolonged exposure.
Author(s): Ironson, Gail , U Miami, Cable Gables, FL, US;
Freud, B.; Strauss, J. L.; Williams, J.
Address: Ironson, Gail, U Miami, Behavioral Medicine Program,
P.O. Box 248185, Coral Gables, FL, 33124-2070, gironson@aol.com
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 113-128.
Publisher: US: John Wiley & Sons.
Abstract: This pilot study compared the efficacy of 2 treatments
for postraumatic stress disorder (PTSD): Eye Movement Desensitization
and Reprocessing (EMDR) and Prolonged Exposure (PE). Data were analyzed
for 22 patients (aged 16-62 yrs) from a university based clinic serving
the outside community (predominantly rape and

death of a family member or a close friend; or learning that one's child has a life threatening disease. The disorder may be especially sever or long lasting when the stressor is of human design (e.g., torture, rape). the likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic event can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event (Criterion B1) or recurrent distressing dreams during which the event can be replayed or otherwise represented (Criterion B2). In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (Criterion B3). These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal. Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for crime victims) who

completed at least 1 active session of treatment after 3 preparatory

sessions. Results showed both approaches produced a significant

reduction in PTSD and depression symptoms, which were maintained at

3-month follow-up. Successful treatment was faster with EMDR as a larger

number of people (7 of 10) had a 70% reduction in PTSD symptoms after 3

active sessions compared to 2 of 12 with PE. EMDR appeared to be better

tolerated as the dropout rate was significantly lower in those

randomized to EMDR versus PE (0 of 10 vs 3 of 10). However all patients

who remained in treatment with PE had a reduction in PTSD scores.

Finally, Subjective Units of Distress (SUDS) ratings decreased

significantly during the initial session of EMDR, but changed little

during PE. Postsession SUDS were significantly lower for EMDR than for

PE. Suggestions for future research are discussed.

Title: The comparative effects of eye movement desensitization and

reprocessing (EMDR) and cognitive behavioral therapy (CBT) in the

treatment of depression.

Author(s): Hogan, William Andrew , Indiana State U., US

Source: Dissertation Abstracts International: Section B: The

Sciences & Engineering , Vol 62(2-B), Aug 2001. pp. 1082.

Publisher: US: Univ Microfilms International.

Abstract: Eye Movement Desensitization and Reprocessing (EMDR) is

a unique, short-term therapy shown to be effective in the treatment of

Posttraumatic Stress Disorder (PTSD). Application of EMDR to the

treatment of depression was considered based upon the relationship

between negative life experience and symptom onset, a pattern common to

both PTSD and depression. Evaluation of the efficacy of EMDR in the

treatment of depression was accomplished via a comparison with cognitive

behavioral therapy (CBT). Because EMDR has been shown to be effective in

the treatment of PTSD, the impact of EMDR and CBT upon symptoms comorbid

to depression was investigated. EMDR was also compared to CBT assessing

the participants' satisfaction. The participants, 15 per treatment

combat veterans of the South Pacific; entering any elevator for an woman who was reaped in an elevator).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event (Criterion C1) and to avoid activities, situations, or people who around recollections of it (Criterion C2). This avoidance of reminders may include amnesia for an important aspect of the traumatic event (Criterion C3). Diminished responsiveness to the external work, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities (Criterion C4), of feeling detached or estranged from other people (Criterion C5), or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness and sexuality) (Criterion C6). The individual may have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span) (Criterion C7).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. these symptoms may include

group, received either one session of EMDR or cognitive behavioral
therapy within the first four sessions. Pre and posttreatment assessment
utilized two standardized instruments evaluating self-report of
depressive and global symptoms. Participant satisfaction was assessed
using a rating scale at posttreatment. Both treatment groups reported
significant reductions in depressive symptoms and global symptoms. There
were no statistical differences between groups on the symptom measures
at posttreatment. Four participants in the EMDR group reported near
complete remission of depressive symptoms and large reductions in global
symptoms. No participants in the CBT group exhibited this pattern of
symptom reduction. Regarding participant satisfaction, participants
perceived EMDR to be less negative than CBT primarily due to the
increased awareness of negative thoughts common to cognitive behavioral
therapy but not experienced in EMDR treatment. The similarity in symptom
reduction reported for both groups suggested the undue influence of
non-specific treatment effects. The marked remission of symptoms
reported by the four participants in the EMDR group parallels the
symptom reductions noted in EMDR studies of PTSD.

Title: Eye movement desensitization and reprocessing: Innovative clinical applications.
Author(s): Protinsky, Howard , Virginia Tech, Marriage & Family Doctoral Program, Blacksburg, VA, US; Sparks, Jennifer; Flemke, Kimberly
Address: Protinsky, Howard, Virginia Tech, Marriage & Family Doctoral Program, 840 University City Blvd, Ste 1, Blacksburg, VA, US, 24061, hprotins@vt.edu
Source: Journal of Contemporary Psychotherapy, Vol 31(2), Sum 2001. pp. 125-135.
Publisher: US: Kluwer Academic/Plenum Publishers.
Abstract: Neurologically-based therapies such as eye movement
desensitization and reprocessing (EMDR) are being clinically implemented
and researched in the field of psychotherapy. While EMDR has a
theoretical base and some research support for its

difficulty falling or staying asleep that may be to recurrent nightmares during which the traumatic event is relived (Criterion D1), hypervigilance (Criterion D4), and exaggerated startle response (Criterion D5). Some individuals report irritability or outburst of anger (Criterion D2) or difficulty concentrating or completing tasks (Criterion D3)."

EMDR

Eye Movement Desensitization and Reprocessing

"Eye Movement Desensitization and Reprocessing (EMDR)[1] integrates elements of many effective psychotherapies in structured protocols that are designed to maximize treatment effects. These include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies[2]. EMDR is an **information processing therapy** and uses an eight phase approach.

During EMDR[1] the client attends to past and present experiences in brief sequential doses while simultaneously focusing on an external stimulus. Then the client is instructed to let new material become the focus of the next set of **dual attention**. This sequence of dual attention and personal association is repeated many times in the session.

effectiveness with posttraumatic stress disorder (PTSD) therapists are now developing and using EMDR for other clinical problems. This report illustrates some of the unique applications of EMDR with clinical problems such as: driving phobia, interpersonal arguments, dyspareunia, depression, anxiety, and eating problems.

Title: Eye movement desensitization and reprocessing in the psychological treatment of combat-related guilt: A study of the effects of eye movements.
Author(s): Cerone, Melanie R. , Temple U., US
Source: Dissertation Abstracts International: Section B: The Sciences & Engineering , Vol 61(10-B), May 2001. pp. 5555.
Publisher: US: Univ Microfilms International.
Abstract: The purpose of this study was to investigate the role of eye movements in Eye Movement Desensitization and Reprocessing (EMDR), and to test the efficacy of EMDR in the treatment of guilt associated with combat trauma. EMDR was compared to a non-eye movement (NEM) analog, which entailed the full EMDR procedure minus the eye movements. A single-case multiple component cross-over design across seven participants was utilized. Participants were combat veterans who were receiving inpatient treatment for Posttraumatic Stress Disorder (PTSD) at the Coatesville Veterans Administration Medical Center. Four participants were introduced first to the EMDR condition and three participants were introduced first to the NEM analog condition. Each participant was exposed to both conditions. Dependent measures included: (1) pre- and post-treatment scores on the Clinician Administered PTSD Scale for DSM-IV - One Week Symptom Status Version (CAPS-SX), Beck Depression Inventory (BDI), Impact of Event Scale (IES), and Trauma Related Guilt Inventory (TRGI), (2) self-monitoring data on the frequency and intensity of intrusive thoughts, disturbing dreams, and guilt, and (3) measures of participants' subjective level of distress within sessions and pre- and post-treatment using the Subjective Units of Distress Scale (SUDS). As measured by SUDS

Eight Phases of Treatment

The first phase is a history taking session during which the therapist assesses the client's readiness for EMDR and develops a treatment plan. Client and therapist identify possible targets for EMDR processing. These include recent distressing events, current situations that elicit emotional disturbance, related historical incidents, and the development of specific skills and behaviors that will be needed by the client in future situations.

During the second phase of treatment, the therapist ensures that the client has adequate methods of handling emotional distress and good coping skills, and that the client is in a relatively stable state. If further stabilization is required, or if additional skills are needed, therapy focuses on providing these. The client is then able to use stress reducing techniques whenever necessary, during or between sessions. However, one goal is not to need these techniques once therapy is complete.

In phase three through six, a target is identified and processed using EMDR procedures. These involve the client identifying the most vivid visual image related to the memory (if available), a negative belief about self, related emotions and body sensations. The client also identifies a preferred positive belief. The validity of the positive belief is

ratings, EMDR resulted in
a greater decrease in dyphoric affect within-session than the NEM
analog. EMDR also resulted in a significant decrease in mean SUDS
ratings from pre- to post-treatment. EMDR resulted in significant
decreases in combat-related PTSD symptomatology, as measured by pre- and
post-treatment scores on the CAPS-SX, BDI, and IES. EMDR also resulted
in significant decreases in mean pre- and post-treatment frequency of
self-reported intrusive thoughts and mean pre- and post-treatment
intensity of intrusive thoughts, disturbing dreams, and guilt.
Additionally, EMDR resulted in a significant decrease in pre- and
post-treatment scores on one scale and two subscales of the TRGI. No
differences in the mean frequency and intensity of self-reported
intrusive thoughts, disturbing dreams, and guilt were detected between
EMDR and the NEM analog. Results of the present study support the role
of eye movements in attaining treatment gains with EMDR. Additionally,
this study supports the efficacy of EMDR in the treatment of
combat-related guilt.

Title: EDMR--Cognitive behavioral method for posttraumatic stress
disorder in torture victims.
Author(s): Ilic, Zoran , Inst for Mental Health, Stress Clinic,
Belgrade, Yugoslavia; Lecic-Tosevski, Dusica; Bokonjic, Srdjan;
Drakulic, Bogdan; Jovic, Vladimir
Source: Psihijatrija Danas , Vol 31(2-3), 1999. pp. 245-258.
Publisher: Yugoslavia: Instituta Za Mentalno Zdravlje.
Abstract: Discusses the theoretical concept of the
cognitive-behavioral method of Eye Movement Desensitization and
Reprocessing (EMDR). The authors describe the use of EMDR as consisting
of 8 phases: the patient's anamnesis and treatment planning, preparing
the patient, assessment, desensitization, installation, scanning of the
body, and closing. The case of a 44-yr-old male with symptoms of
posttraumatic stress disorder (PTSD) associated with depressive symptoms
who was treated with EMDR is presented. Two mo after EMDR, the S had no

rated, as is the intensity of the negative emotions.

After this, the client is instructed to focus on the image, negative thought, and body sensations while simultaneously moving his/her eyes back and forth following the therapist's fingers as they move across his/her field of vision for 20-30 seconds or more, depending upon the need of the client. Athough **eye movements** are the most commonly used external stimulus, therapists often use auditory tones, tapping, or other types of tactile stimulation. The kind of dual attention and the length of each set is customized to the need of the client. The client is instructed to just notice whatever happens. After this, the clinician instructs the client to let his/her mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind. Depending upon the client's report the clinician will facilitate the next focus of attention. In most cases a client-directed association process is encouraged. This is repeated numerous times throughout the session. If the client becomes distressed or has difficulty with the process, the therapist follows established procedures to help the client resume processing. When the client reports no distress related to the targeted memory, the clinician asks him/her to think of the preferred positive belief that was identified at the beginning of the clinical manifestations of PTSD and he did not have them at the repeated
test examination, so resocialization started aimed at the reduction of
avoidance symptoms.

Title: Eye movement desensitization and reprocessing: Evaluating its
effectiveness in reducing trauma symptoms in adult female survivors of
childhood sexual abuse.
Author(s): Edmond, Tonya Elaine , U Texas at Austin, US
Source: Dissertation Abstracts International Section A:
Humanities & Social Sciences , Vol 59(2-A), Aug 1998. pp. 0617.
Publisher: US: University Microfilms International.
Abstract: The purpose of the study was to evaluate, through the
use of a randomized experimental design, the effectiveness of EMDR in
reducing trauma symptoms in adult female survivors of childhood sexual
abuse. No EMDR research to date has been exclusively comprised of adult
survivors of childhood sexual abuse, a historically difficult treatment
population. Additionally, while numerous clinical accounts of treatment
with sexual abuse survivors have been published, controlled treatment
research has rarely been done. Of the studies found that examine
treatment efficacy exclusively with this population, none involved the
use of random assignment. A sample of sixty adult female sexual abuse
survivors were selected and randomly assigned to one of three groups:
(1) individual EMDR treatment; (2) individual eclectic treatment; or (3)
delayed treatment control group. The participating survivors' trauma
symptoms were measured in pretests and posttests on standardized as well
as subjective instruments that measured anxiety, posttraumatic stress,
depression, negative beliefs about the sexual abuse, emotional distress
and desired positive self beliefs. The survivors' in the study assigned
to the experimental or comparison treatment groups received six 90
minute individual sessions of either EMDR or eclectic therapy. The
delayed treatment control group subjects were pretested, asked to delay
treatment for six weeks, and after being post tested were assigned a

session, or a better one if it has emerged, and to focus on the incident, while simultaneously engaging in the eye movements. After several sets, clients generally report increased confidence in this positive belief. The therapist checks with the client regarding body sensations. If there are negative sensations, these are processed as above. If there are positive sensations, they are further enhanced.

In phase seven, closure, the therapist asks the client to keep a journal during the week to document any related material that may arise and reminds the client of the self-calming activities that were mastered in phase two.

The next session begins with phase eight, re-evaluation of the previous work, and of progress since the previous session. EMDR treatment ensures processing of all related historical events, current incidents that elicit distress, and future scenarios that will require different responses. The overall goal is produce the most comprehensive and profound treatment effects in the shortest period of time, while simultaneously maintaining a stable client within a balanced system.

After EMDR processing, clients generally report that the emotional distress related to the memory has been eliminated, or greatly decreased, and that they have gained important cognitive

therapist with which to work. Data analysis consisted primarily of multivariate and univariate analysis of variance. The posttest results indicated that EMDR was very effective in reducing the targeted trauma symptoms compared to the control group. Eclectic therapy at posttest was also found to be very effective, resulting in a lack of statistically significant differences between the experimental and comparison treatments. However, analysis conducted at the three month follow-up revealed that EMDR was significantly more effective than eclectic therapy at maintaining therapeutic gains. The results of this study suggest that while both EMDR and eclectic therapy, when applied as brief psychotherapy models of treatment for survivors, can produce significant alleviation of trauma symptoms, EMDR may provide more enduring resolution. These findings have important implications for both survivors and the service providers available to them.

Title: EMDR terms and procedures: Resolution of uncomplicated depression.
Author(s): Manfield, Philip
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook of innovative applications. New York, NY, US: W. W. Norton & Co, Inc. pp. 15-36
Abstract: This chapter presents an example of a relatively uncomplicated eye movement desensitization and reprocessing (EMDR) treatment, which can provide a basis for understanding the more complex aspects of cases. The Ss was a man in his 40s with depression who completed 9 sessions of EMDR to help the client focus on sources of disturbing affect, maladaptive world views, and negative self-perceptions, desensitizing these and processing them in an accelerated way until an adaptive resolution was achieved. The EMDR process involved identifying targets for EMDR, identifying an image or memory that elicits comfortable feelings, desensitization to the target, and the cognitive interweave process of providing the client with information that the client has not linked to the

insights. Importantly, these emotional and cognitive changes usually result in spontaneous behavioral and personal change, which are further enhanced with standard EMDR procedures." www.emdr.com

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1Shapiro, F. (2001). Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (2nd ed.). New York: Guilford Press.

2Shapiro, F. (2002). EMDR as an Integrative Psychotherapy Approach: Experts of Diverse Orientations Explore the Paradigm Prism. Washington, DC: American Psychological Association Books.

target. /// In the
treatment described, the S's depression completely lifted and he was
able to deal more comfortably with problems. After 2 yrs, the results
achieved during these 9 sessions had endured.

Title: Postpartum depression: Helping a new mother to bond.
Author(s): Parnell, Laurel , California Inst of Integral Studies,
San Francisco, CA, US
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook
of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 37-64
Abstract: Presents the case of a new mother who suffered from
acute postpartum depression and was unable to bond with or care for her
new baby. The case demonstrates how a therapist can integrate eye
movement desensitization and reprocessing (EMDR) with dreams, imagery,
and inner child work in intensive brief therapy. The S was a previously
high-functioning woman with obsessive-compulsive tendencies who began to
suffer from psychotic-like thoughts and postpartum depression. The
therapist worked with the S over 4 wks. The 1st sessions focused on
history-taking, assessment, stabilization, anxiety reduction, and
development of a trusting relationship. Relaxation and inner child work
were used to help ease the S's distress. The initial EMDR session was
also used primarily for anxiety reduction. Subsequent EMDR sessions were
more focused to developed targets that included disturbing images,
emotions, body sensations, and negative connotations. The S's symptoms
began to diminish rapidly following EMDR sessions, culminating in a
significant improvement in functioning. EMDR helped the S to distinguish
what was in the past and what was in the present and facilitated an
integration of the previously split-off self-constructs of good girl and
bad girl.

Title: Filling the void: Resolution of a major depression.
Author(s): Manfield, Philip
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook

of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 113-137
Abstract: Presents the case of a 36-yr-old woman who was treated with eye movement desensitization and reprocessing (EMDR) for major depression that occurred after surgery for the removal of a large benign growth next to her stomach. Although the S's immediate complaint was depression, she was also continuing to encounter life-long difficulties in her relationships and career choices. This case demonstrates the value of EMDR in rapidly resolving major depression by processing a series of traumatic memories. The themes of loss, overwhelming helplessness, and inadequacy weave through each of these memories and tie them together. Although major depression is not one of the diagnoses typically thought of as responsive to EMDR, this case shows the breadth of change the S experienced as a result of processing traumatic memories and follow-up integrative work. EMDR helped relieve the depression and a cluster of other issues that appeared to be more characterological.

Title: Imaginary crimes: Resolving survivor guilt and writer's block.
Author(s): Engel, Lewis , Private Practice, San Francisco, CA, US
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 138-163
Abstract: Presents the case of a 45-yr-old female with depression, obsessions about an ex-boyfriend, and writing block who was treated with control mastery theory that used eye movement desensitization and reprocessing (EMDR) as an exploratory tool and treatment method. Issues of survivor guilt toward her murdered sister, identification with her anxious, unhappy mother, and compliance with her critical and rejecting father were addressed and at least partially worked through in the first 11 sessions of treatment. The S's depression has lifted, she has been able to write freely, and she has stopped obsessing about her ex-boyfriend. The therapist was able to combine cognitive mastery theory

and EMDR to create a rapid but deep exploration and amelioration of the
client's major, longstanding life problems.

Title: Healing hidden pain: Resolving the effects of childhood abuse
and neglect.
Author(s): Vogelmann-Sine, Silke
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook
of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 167-190
Abstract: Presents the case of a woman who was treated with eye
movement desensitization and reprocessing (EMDR) for major depression
and the remembered trauma of childhood abuse and neglect. The case
demonstrates that EMDR is a tool that can help clients go back in time
and develop those parts of their personalities that could not emerge
because of an invalidating environment. EMDR allowed the S to access
dissociated feelings and memories from her past. Over time, the S
reprocessed the pain experienced in her childhood and was freed to
perceive the world from an adult point of view. Her trauma recovery
allowed her to be more in touch with her feelings, to believe that the
world was a safer place, and to acquire self-worth.

Title: "Am I Real?": Mobilizing inner strength to develop a mature
identity.
Author(s): Lovett, Joan
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook
of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 191-216
Abstract: Presents the case of a 44-yr-old woman who had extremely
low self-esteem, depression, panic attacks, and symptoms of dissociation
when she began eye movement desensitization and reprocessing (EMDR)
therapy. Eye movement was used initially to reinforce healthy beliefs,
physical sensations, and feelings related to experiences of safety,
competence, well-being, and success based on prior learning. EMDR was
then employed to target painful memories of childhood scenes with her
parents, as well as erroneous beliefs and feelings of intense anxiety.

Although none of the memories targeted occurred before age 5, the empty
feeling that was targeted seemed to represent an earlier deprivation.
The desired positive cognition "I am significant" became an umbrella
cognition containing various sub-cognitions (e.g., "I am lovable").
As the S reprocessed traumatic childhood memories with EMDR, more of
these sub-cognitions were integrated. Reprocessing the client's issues
as she presented them led to a more stable, flexible, and resilient
sense of self.

Title: Lifing the burden of shame: Using EMDR resource installation to
resolve a therapeutic impasse.
Author(s): Leeds, Andrew M.
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook
of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 256-281
Abstract: Presents a case of a woman with depression and social
isolation, a debilitating physical illness, and a history of childhood
abuse and neglect. In this case, eye movement desensitization and
reprocessing (EMDR) was used as a resource installation to resolve a
therapeutic impasse and to help the client overcome feelings of shame.
The author discusses the initiation of EMDR treatment, emotional
flooding and a failed early installation, countertransference and demand
characteristics, and integrating the use of imaginal resources in
posttraumatic stress disorder (PTSD) EMDR protocols. The author also
describes the scientific foundations for the use of imaginal resources
and sources for principles used in resource installation.

Title: Extending EMDR: A casebook of innovative applications.
Author(s): Manfield, Philip , (Ed)
Source: 1998. New York, NY, US: W. W. Norton & Co, Inc. xii, 292
pp.
Abstract: Explores the use of eye movement sensitization and
reprocessing (EMDR) in the treatment of residual psychological effects
of a single-incident trauma, long-term childhood abuse,and complex

posttraumatic stress disorder (PTSD). The eleven case reports provided
illustrate the application of EMDR to a broad range of cases. The
introduction includes basic descriptions of EMDR and the accelerated
information processing model, as well as definitions of its terminology.
Each of the following chapters begins with a discussion of the
contributor's background, the principles of the traditional treatment
approach used before incorporating EMDR, and the way he or she has
integrated EMDR into that approach. The book is divided into two
parts: those cases in which it was possible to target a relatively small
number of distinct traumatic experiences, and those in which the
clients' symptoms have resulted from ongoing childhood trauma or neglect
for which they are unable to identify representative discrete trauma.
The description of the client's treatment and progress is detailed
enough to enable the reader to understand how the results were achieved.
Finally, the duration and outcome of each case are evaluated.
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Title: Controlled study of treatment of PTSD using EMDR in an HMO
setting.
Author(s): Marcus, Steven V. , The Permanente Medical Group, Inc.,
Dept of Psychiatry, Santa Clara, CA, US; Marquis, Priscilla;
Sakai, Caroline
Source: Psychotherapy: Theory, Research, Practice, Training ,
Vol 34(3), Fal 1997. pp. 307-315.
Publisher: US: Div of Psychotherapy APA.
Abstract: 67 individuals (aged 18-73 yrs) diagnosed with
posttraumatic stress disorder (PTSD) were randomly assigned to either
Eye Movement Desensitization and Reprocessing (EMDR) treatment or
Standard Care (SC) treatment. Participants were assessed pretreatment,
after 3 sessions, and at the completion of treatment using the SCL-90,
Beck Depression Inventory, Impact of Event Scale (M. Horowitz et al,
1979), modified PTSD Symptom Scale (S. A. Falsetti et al, 1993), State
Trait Anxiety Inventory, and other measures. In addition, an independent
evaluator assessed participants using Diagnostic and Statistical Manual
of Mental Disorders-III-Revised (DSM-III-R) criteria for PTSD including
Global Assessment of Functioning at the 3 data points. Ss in the EMDR
treatment group showed significantly greater improvement with greater
rapidity than those in the SC treatment group on measures of PTSD,
depression, anxiety, and general symptoms. Ss who received EMDR

treatment used fewer medication appointments for their psychological
symptoms and needed fewer psychotherapy appointments.

Title: A controlled study of eye movement desensitization and
reprocessing in the treatment of posttraumatic stress disordered sexual
assault victims.
Author(s): Rothbaum, Barbara Olasov, Emory U, School of Medicine,
Dept of Psychiatry & Behavioral Sciences, Atlanta, GA, US
Source: Bulletin of the Menninger Clinic, Vol 61 (3), Sum 1997.
pp. 317-334.
Publisher: US: Menninger Foundation.
Abstract: Eye movement desensitization and reprocessing (EMDR) is
a new method developed to treatment posttraumatic stress disorder
(PTSD). This study evaluated the efficacy of EMDR compared to a
no-treatment wait-list control in the treatment of PTSD in adult female
sexual assault victims. 21 Ss entered the study, and 18 completed the
study. Treatment was delivered in 4 weekly individual sessions.
Assessments were conducted pre- and posttreatment and 3 mo following
treatment termination by an independent assessor kept blind to treatment
condition. Results indicate that Ss treated with EMDR improved
significantly more on PTSD and depression from pre- to posttreatment
than control Ss.

Title: Eye movement desensitization and reprocessing: A multiple
baseline study.
Author(s): Zeper, Robbi Schlaffman , The Union Inst, US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 57(8-B), Feb 1997.
pp. 5350.
Publisher: US: Univ Microfilms International.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) was
developed in 1987 by Francine Shapiro, as a modality for relieving
anxiety, traumatic memories, intrusive thoughts, and reprocessing
negative self-beliefs to positive self-beliefs. One of the most common
uses of EMDR in recent years has been the treatment of Post Traumatic

Stress Disorder (PTSD). This current study investigated the effects of EMDR across a sample of 3 sexually abused women diagnosed with PTSD using a multiple baseline design across subjects. The study specifically focused on whether or not intervention with EMDR effects traumatic memory and negative/irrational cognitions, decreases stress or changes levels of anxiety, depression and heart rate. The study intended to assess the efficacy of EMDR while simultaneously reduce human suffering and answer some of the more serious criticisms which have blurred confidence in EMDR outcome research. Specifically, the study controlled for a number of the criticisms in the literature predominantly through a confirmation of an accurate PTSD diagnosis and through the use of a multiple baseline design. The multiple baseline design was applied sequentially to the same problem across different but matched subjects sharing the same environmental conditions. Heart rate level and well-known psychometrics were used to obtain baseline, intervention and post-intervention measures. Psychometric scores reflecting levels of depression, anxiety, and subjective levels of the impact of distress regarding the trauma were assessed along with the levels of anxiety currently experienced about the trauma and subjective ratings regarding the acceptance of the preferred, self-generated positive cognition. The measures used in this study were an initial clinical interview, an Anxiety Disorders Interview Schedule for the DSM IV (Brown, DiNardo & Barlow, 1994), Beck Depression Inventory (Beck, Rush, Shaw & Emery, 1979), Beck Anxiety Inventory (Beck, 1993), Wolpe's Subjective Unit of

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Translated Title: Eye movement desensitization and reprocessing (EMDR) treatment for combat-related posttraumatic stress disorder.

Author(s): Carlson, John G., U Hawaii at Manoa, Dept of Psychology, Honolulu, HI, US; Chemtob, Claude M.; Rusnak, Kristin Hedlund, Nancy L.; Muraoka, Miles Y.

Source: Japanese Journal of Biofeedback Research , Vol 24, 1997. pp. 50-64.

Publisher: Japan: Japanese Society of Biofeedback Research.
Abstract: Studied the efficacy of eye movement desensitization and reprocessing (EMDR) treatment for combat-related posttraumatic stress disorder (PTSD). Human Ss: 35 male American adults (aged 41-70 yrs) (PTSD) (34 Vietnam War veterans and 1 Korean War veteran). Tests used: The Clinician Administered PTSD Scale (D. D. Blake et al, 1995), the restandardized MMPI, the Mississippi Scale for Combat Related PTSD (T. M. Keane et al, 1988), the State-Trait Anxiety Inventory, the Beck Depression Inventory, the Impact of Events Scale and the Initial Screening Questionnaire. Treatments: 10 Ss were administered 12 EMDR sessions, 13 Ss were administered 12 sessions of biofeedback and relaxation, and 12 Ss were administered standard treatment.

Title: EMDR: The breakthrough therapy for overcoming anxiety, stress, and trauma.
Author(s): Shapiro, Francine , Mental Research Inst, Palo Alto, CA, US; Forrest, Margot Silk
Source: 1997. New York, NY, US: Basic Books, Inc. xii, 285 pp.
Abstract: EMDR (Eye Movement Desensitization and Reprocessing) is the innovative clinical treatment which has . . . helped individuals who have survived trauma--including sexual abuse, domestic violence, drive-by-shooting, combat and crime, as well as those who suffer from depression, addiction and phobias. Through numerous case examples, [this book] illustrates the effectiveness of Dr. Shapiro's . . . method. Readers will see the causes for a wide variety of symptoms and how they can be managed.
Table of Contents: Acknowledgments
..The journey of discovery
..Laying the foundation
..The spirit and the sword: Combat's tragic legacy
..The fabric of treatment: Uncovering the hidden depths of pain
..The many faces of fear: Phobias and panic attacks
..When terror stalks the night: Sleep disorders and childhood trauma
..The ties that bind: Disorders of attachment
..Healing the ravages of rape
..Laying grief to rest
..Breaking the iron grasp of addiction

Title: Transforming trauma: EMDR: The revolutionary new therapy for freeing the mind, clearing the body, and opening the heart.
Author(s): Parnell, Laurel
Source: 1997. 287 pp.
Abstract: Eye movement desensitization and reprocessing (EMDR) has helped thousands of clients haunted by terrible abuse histories or recent traumatic events. It also benefits patients who have not found relief with other therapies and those with such chronic conditions as eating disorders, anxiety, low self-esteem, depression, and blocked personal and professional performance. /// Drawing on her own experiences as both EMDR client and therapist, [the author] shares . . .stories of healing by taking readers into her clients' psyches, where past traumas frozen in time are witnessed and then released.

Title: Treatment of Vietnam War veterans with PTSD: A comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training.
Author(s): Silver, Steven M. , Veterans Affairs Medical Ctr, Posttraumatic Stress Disorder Program, Coatesville, PA, US; Brooks, Alvin; Obenchain, Jeanne
Source: Journal of Traumatic Stress , Vol 8(2), Apr 1995. pp. 337-342.

Publisher: US: Kluwer Academic/Plenum Publishers.
Abstract: Compared eye movement desensitization and reprocessing (EMDR), biofeedback (BF), and relaxation training (RT) in the treatment of Vietnam War veterans with posttraumatic stress disorder (PTSD). An inhouse program evaluation of an inpatient PTSD program was conducted during 1990-1991. 100 veterans (mean age 46 yrs) were offered EMDR, BF and group-run RT treatment in the program. Patient responses to a set of scales were collected during evaluation, at admission, and at discharge. Differences between Ss' ratings on entry and exit were used. Results show that EMDR is an effective technique in the treatment of PTSD. It produced positive incremental change in the PTSD program for nightmares, intrusive thoughts, flashbacks, anxiety, anger, depression, and relationship problems. RT produced more positive effects than BF when compared to the control group. Flaws of the study are highlighted.

Title: Use of EMDR in a "dementing" PTSD survivor.
Author(s): Hyer, Lee, Veterans Affairs Medical Ctr, Augusta, GA, US
Source: Clinical Gerontologist, Vol 16(1), 1995. pp. 70-73.
Publisher: US: Haworth Press.
Abstract: Presents a case study of a 72-yr-old woman with dementia to examine the usefulness of eye movement desensitization and reprocessing (EMDR) in treating posttraumatic stress disorder (PTSD) in "dementing" elderly. EDMR is a therapeutic tool in which clients are made to reexperience and cognitively reprocess their trauma in imagination, moving their eyes simultaneously. It is reported to be a good instrument in treating younger survivors of trauma, however, a few studies support its use in elderly. The S experienced a series of traumatizing events. Test results showed that the S had symptoms of PTSD, depression, anxiety, and borderline dementia. After 3 sessions of EDMR, significant improvement was seen in the S, who was ready to start and lead a normal life. It is suggested that EDMR allows the client to

participate in the past as currently real, and to evaluate the unfolding
of the process from an observer perspective.

Title: Eye movement desensitization and reprocessing for panic
disorder: A case series.
Author(s): Goldstein, Alan J. , Agoraphobia & Anxiety Treatment
Ctr, Bala Cynwyd, PA, US; Feske, Ulrike
Source: Journal of Anxiety Disorders, Vol 8(4), Oct-Dec 1994.
pp. 351-362.
Publisher: US: Elsevier Science.
Abstract: Evaluated Eye Movement Desensitization and Reprocessing
(EMDR), a technique that has shown some promise in the treatment of
traumatic memories. Seven clients (aged 25-50 yrs) suffering from panic
disorder received EMDR treatment for memories of past and anticipated
panic attacks and other anxiety-evoking memories of personal relevance.
After 5 sessions of EMDR, Ss reported a considerable decrease in the
frequency of panic attacks, fear of experiencing a panic attack, general
anxiety, thoughts concerning negative consequences of experiencing
anxiety, fear of body sensations, depression, and other measures of
pathology.

Title: PTSD in an elderly male: Treatment with eye movement
desensitization and reprocessing (EMDR).
Author(s): Thomas, Robert, Dept of Veterans Affairs Medical Ctr,
Family Therapy Training Program, Tucson, AZ, US; Gafner, George
Source: Clinical Gerontologist, Vol 14(2), 1993.
pp. 57-59.
Publisher: US: Haworth Press.
Abstract: Administered EMDR to a 68-yr-old Native American man who
suffered startle reactions, nightmares, and other posttraumatic stress
disorder (PTSD) symptoms since service in World War II and the Korean
War. Prior to EMDR, the S had moderate to severe depression; following 1
EMDR trial, depression was reduced to a mild level. After 2 EMDR
sessions, his PTSD symptoms were ameliorated.

Title: Outcome Predictors for Three PTSD Treatments: Exposure Therapy,
EMDR, and Relaxation Training.

Author(s): Taylor, Steven , U British Columbia, Vancouver, BC,
Canada
Address: Taylor, Steven, University of British Columbia,
Vancouver, BC, Canada
Source: Journal of Cognitive Psychotherapy , Vol 17(2), Sum
2003. Special Issue on Posttraumatic Stress Disorder. pp. 149-161.
Publisher: US: Springer Publishing.
Abstract: Several psychosocial treatments appear to be effective
in treating posttraumatic stress disorder (PTSD). However, little is
known about the predictors of treatment outcome. It is possible that
some variables predict poor outcome for some treatments but not for
other treatments. To investigate this issue, outcome predictors were
investigated for three eight-session treatments: exposure therapy
(entailing prolonged imaginal and in vivo exposure), relaxation
training, and eye movement desensitization and reprocessing (EMDR).
Sixty people with PTSD entered and 45 completed treatment. Treatments
did not differ in attrition or perceived credibility. Exposure tended to
be most effective, and EMDR and relaxation did not differ in efficacy. A
number of clinical and cognitive variables were examined to identify
predictors of treatment dropout as well as predictors of the likelihood
that patients would be remitted from PTSD after treatment. These
analyses were conducted by controlling for treatment condition. Low
patient ratings of treatment credibility (assessed in session 2)
predicted treatment dropout, regardless of treatment type. Severe
reexperiencing symptoms (assessed prior to treatment) predicted poor
outcome for relaxation training but not for the other therapies...

Title: Comparative efficacy, speed, and adverse effects of three PTSD
treatments: Exposure therapy, EMDR, and relaxation training.
Author(s): Taylor, Steven, U British Columbia, Dept of Psychiatry,
Vancouver, BC, Canada;
Thordarson, Dana S., U British Columbia, Dept of Psychiatry, Vancouver,
BC, Canada;
Maxfield, Louise, Lakehead U, Dept of Psychology,

Thunder Bay, ON,
Canada;
Fedoroff, Ingrid C., St Paul's Hosp, Vancouver, BC, Canada;
Lovell, Karina , U Manchester, School of Nursing, Midwifery, & Health
Visiting, Manchester, England;
Ogrodniczuk, John , U British Columbia, Dept of Psychiatry, Vancouver,
BC, Canada
Address: Taylor, Steven, U British Columbia, Dept of Psychiatry,
2255 Wesbrook Mall, Vancouver, BC, Canada, V6T 2A1, taylor@unixg.ubc.ca
Source: Journal of Consulting & Clinical Psychology , Vol 71(2),
Apr 2003. pp. 330-338.
Publisher: US: American Psychological Assn.
Abstract: The authors examined the efficacy, speed, and incidence
of symptom worsening for 3 treatments of posttraumatic stress disorder
(PTSD): prolonged exposure, relaxation training, or eye movement
desensitization and reprocessing (EMDR; N=60). Treatments did not differ
in attrition, in the incidence of symptom worsening, or in their effects
on numbing and hyperarousal symptoms. Compared with EMDR and relaxation
training, exposure therapy (a) produced significantly larger reductions
in avoidance and reexperiencing symptoms, (b) tended to be faster at
reducing avoidance, and (c) tended to yield a greater proportion of
participants who no longer met criteria for PTSD after treatment. EMDR
and relaxation did not differ from one another in speed or efficacy.
Conference: World Congress of Behavioral and Cognitive Therapies.,
Jul, 2001, Vancouver, BC, Canada

Title: The effect of EMDR on the pathophysiology of PTSD.
Author(s): Smith, Stacy ,
stacy.m.smith@worldnet.att.net, Loyola Coll, Baltimore, MD, US
Address: Smith, Stacy, 4700 Hampnett Ave., Baltimore, MD, US,
21214, stacy.m.smith@worldnet.att.net
Source: International Journal of Emergency Mental Health , Vol
5(2), Spr 2003. pp. 85-91.
Publisher: US: Chevron Publishing.
Abstract: The process of understanding Posttraumatic Stress
Disorder (PTSD) has been a long and difficult one. It is safe to say our
understanding of this disorder is incomplete, and

our exploration into its pathophysiology is fairly recent. As with any disorder of the brain, the complexities of PTSD are extensive and require integrating cognitive, functional, and chemical components. Given this complexity, it is no wonder that treating PTSD has also been a challenge. Treating a disorder whose components are not fully understood is similar to shooting in the dark. Some shots have hit their mark and some have missed. More than ten years after its conception, the question of whether Eye Movement Desensitization and Reprocessing (EMDR) is a hit or a miss is still debated. If understanding the pathophysiology of PTSD is still recent, understanding the possible physiology behind EMDR is just beginning. This paper will define PTSD, explain some aspects of its physiology, and present some hypotheses as to why EMDR may be a successful treatment for PTSD.

Title: Integration of EMDR with other therapeutic approaches: A survey investigation.
Author(s): Lyhus, Kristina Ellen , The Catholic U America, US
Source: Dissertation Abstracts International: Section B: The Sciences & Engineering, Vol 63(10-B), 2003. pp. 4912.
Publisher: US: Univ Microfilms International.
Abstract: The present study examined assimilative integration, i.e., when techniques from various therapeutic approaches are imported into a single, consistent theoretical framework. Specifically, the aim of this study was to investigate how Eye Movement Desensitization and Reprocessing (EMDR), a manualized therapeutic approach originally developed as a treatment for traumatic memories, is incorporated into clinical practice. In assimilative integration, elements of the EMDR protocol would be expected to be conceptualized and possibly modified in ways that are consistent with the therapist's theoretical framework. A survey design, using web-based questionnaires, was implemented to gather information from therapists who use EMDR. Therapists responded to a broad range of questions regarding their theoretical orientation,

involvement in EMDR organizations, and practice of EMDR. A large sample (N = 532) was obtained, and results demonstrated that most therapists integrated EMDR with other therapeutic methods. Further, there was some evidence that therapists were practicing assimilative integration. Specifically, therapists typically added methods consistent with their primary theoretical orientation and conceptualized the effective elements of EMDR as those that were most consistent with their orientation. Most therapists reported using most of the elements of the EMDR protocol, perhaps reflecting the high level of interest in EMDR among therapists in the sample. However, there were some differences related to therapists' level of commitment to EMDR. For example, members of the EMDR International Association used more elements of the protocol and were more likely to report that they did not combine other methods with EMDR when compared to nonmembers. The diagnosis of the client was also an important factor in how EMDR was integrated into treatment. For example, therapists treating clients with PTSD were more likely to report on their use of EMDR as the primary therapeutic approach and to integrate cognitive/behavioral methods than were those treating clients with other disorders. This study was among the first to examine the process of assimilative integration. The findings show that psychotherapy integration varies by therapists' base theoretical orientation, client factors, and therapists' commitment to the treatment method being integrated.

Title: A Look at EMDR: Technique, Research, and Use with College Students.
Author(s): Sikes, Charlotte K., Charlotte-sikes@uiowa.edu; Sikes, Victoria N.
Address: Sikes, Charlotte K., 16 N 7th Avenue, Iowa City, IA, US, 52245, Charlotte-sikes@uiowa.edu
Source: Journal of College Student Psychotherapy , Vol 18(1), 2003. pp. 65-76.
Publisher: US: Haworth Press.
Abstract: Eye-Movement Desensitization and Reprocessing (EMDR),

often resulting in dramatic symptom relief in clients, has become an increasingly popular treatment for Post-traumatic Stress Disorder (PTSD) and a variety of other diagnoses and symptoms. EMDR may prove more effective and timely than other methods in treating college students for a number of common presenting concerns, particularly within the framework of the brief therapy model. The following article will provide an overview of the process of and theory behind EMDR treatment, and the current research on its outcomes. The use of EMDR in treating college students will then be considered.

Title: Augmenting exposure therapy with other CBT procedures.
Author(s): Foa, Edna B., U Pennsylvania, Dept of Psychiatry, Philadelphia, PA, US;
Rothbaum, Barbara O., Emory U School of Medicine, Atlanta, GA, US;
Furr, Jami M., U Pennsylvania, Philadelphia, PA, US
Address: Foa, Edna B., U Pennsylvania, Dept of Psychiatry, Ctr for the Treatment of Anxiety, 3535 Market St, 6th floor, Philadelphia, PA, US, 19104
Source: Psychiatric Annals , Vol 33(1), Jan 2003. pp. 47-53.
Publisher: US: SLACK.
Abstract: Most studies on treatment outcome for posttraumatic stress disorder (PTSD) have used cognitive behavioral therapy (CBR) programs, which include variants of exposure therapy, anxiety management, and cognitive therapy. Combinations of these interventions have also been investigated. More recently, eye movement desensitization and reprocessing (EMDR) has been employed for the treatment of PTSD, and a number of studies have explored its efficacy. In the treatment guidelines developed under the auspices of the International Society for Traumatic Stress Studies, exposure therapy has emerged as the most empirically supported intervention for PTSD. In this article the authors focus on reviewing well-controlled studies that compared the efficacy of exposure therapy to that of other interventions. In comparing outcome across studies, the focus is on percent change from baseline on the main PTSD measure calculated on completers whenever

possible. Result suggest
that exposure therapy is highly effective; treatment effects appear to
be diminished by diluting exposure therapy when attempting to augment it
with other treatments.

Title: EDMR and the role of the clinician in psychotherapy evaluation:
Towards a more comprehensive integration of science and practice.
Author(s): Shapiro, Francine , Medical Research Inst, US
Address: Shapiro, Francine, P. O. Box 51010, Pacific Grove, CA,
US, 95497, Fshapiro@emdr.org
Source: Journal of Clinical Psychology, Vol 58 (12), Dec 2002.
pp. 1453-1463.
Publisher: US: John Wiley & Sons.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) is
an integrative psychotherapy approach that has been consistently
evaluated as efficacious in the treatment of posttraumatic stress
disorder (PTSD). The information processing model that guides its
clinical application posits that EMDR should be effective in treating
other psychological disorders that have experiential contributors.
Research is needed to assess such applications. This special issue
features three case series in which EMDR was applied to the treatment of
complex PTSD, phobias, and chronic pain, respectively. The authors
discuss deficits in the research literature, provide preliminary data on
EMDR treatment of these conditions, and offer descriptive guidelines for
evaluation that are achievable by the practicing clinician. Two
additional articles offer preliminary data on physiological and
cognitive/affective concomitants of therapeutic change. It is argued
that clinicians should play a greater role in the rigorous and extensive
examination of psychological treatments in the context of the exigencies
of clinical practice.

Title: Preliminary evidence of efficacy for EMDR resource development
and installation in the stabilization phase of treatment of complex
posttraumatic stress disorder.
Author(s): Korn, Deborah L., Private Practice,

Needham, MA, US;
Leeds, Andrew M., Private Practice, Santa Rosa, CA, US
Address: Korn, Deborah L., Private Practice, 400 Hunnewell
Street, Suite 3, Needham, MA, US, 02494, DLKorn@erols.com
Source: Journal of Clinical Psychology, Vol 58(12), Dec 2002.
pp. 1465-1487.
Publisher: US: John Wiley & Sons.
Abstract: Reviews the complexity of adaptation and symptomatology
in 2 female adult survivors (aged 39 and 31 yrs) of childhood neglect
and abuse who meet criteria for the proposed diagnosis of Complex
Posttraumatic Stress Disorder (Complex PTSD), also known as Disorders of
Extreme Stress, Not Otherwise Specified (DESNOS). A specific EMDR
protocol, Resource Development and Installation (RDI), is proposed as an
effective intervention in the initial stabilization phase of treatment
with Complex PTSD/DESNOS. Descriptive psychometric and behavioral
outcome measures from 2 single case studies are presented which appear
to support the use of RDI. Suggestions are offered for future treatment
outcome research with this challenging population.

Title: Salivary cortisol levels and the cortisol response to
dexamethasone before and after EMDR: A case report.
Author(s): Heber, Ruth , Mount Sinai School of Medicine, New York,
NY, US;
Kellner, Michael , U Hospital Eppendorf, Hamburg, Germany;
Yehuda, Rachel , Mount Sinai School of Medicine, New York, NY, US
Address: Heber, Ruth, 200 East 33rd Street, Apt. 4-i, New York,
NY, US, 10016, rthbr@bellatlantic.net
Source: Journal of Clinical Psychology, Vol 58 (12), Dec 2002.
pp. 1521-1530.
Publisher: US: John Wiley & Sons.
Abstract: Reports a case study in which pre and post-Eye Movement
Desensitization and Reprocessing (EMDR) treatment salivary cortisol
levels and salivary cortisol response to 0.50 mg of dexamethasone were
measured in a 41-yr-old female with chronic posttraumatic stress
disorder (PTSD) symptoms. The author's goal was to determine whether

symptom improvement following trauma-focused treatment (EMDR) is
associated with changes in basal salivary cortisol or in the cortisol
response to dexamethasone administration. Findings show moderate symptom
improvement, an increase in basal cortisol levels, and a more attenuated
cortisol hypersuppression in response to the dexamethasone suppression
test following EMDR treatment. Results suggest the potential utility of
including neuroendocrine measures in the assessment of treatment outcome
in PTSD.

Title: EMDR for women who experience traumatic events.
Author(s): Peterson, Gary , Southeast Inst for Group & Family
Therapy, Chapel Hill, NC, US
Source: Journal of Clinical Psychiatry, Vol 63(11), Nov 2002.
pp. 1047-1048.
Publisher: US: Physicians Postgraduate Press.
Abstract: Comments on an article by E. B. Foa and G. P. Street
regarding psychotherapeutic interventions for women with PTSD. It is noted that Foa and Street describe other
psychotherapy procedures, but do not mention eye movement
desensitization and reprocessing (EMDR). Peterson cites that in
Effective Treatments for PTSD: Practice Guidelines from the
International Society for Traumatic Stress Studies [ISTSS] , 2
psychotherapy treatments for PTSD are listed as having been shown to be
effective: exposure therapy and EMDR. SIT is reported to have had 2
well-controlled studies published on the treatment of PTSD. Both SIT
studies were with female sexual assault victims. It is concluded that
given that EMDR has been established as effective in the ISTSS
guidelines, it may be important for the reader to know that this form of
therapy may be applied when confronting the issues addressed in this
article. A comment by Foa follows.

Title: Treatment of PTSD: Stress Inoculation Training with Prolonged
Exposure compared to EMDR.
Author(s): Lee, Christopher, Sir Charles Gairdner Hosp, QEII
Medical Ctr, Perth, Australia;

Gavriel, Helen, HMAS Stirling, Royal Australian Navy, Australia;
Drummond, Peter, Murdoch U, School of Psychology, Perth, Australia;
Richards, Jeff, U Ballarat, Ballarat, Australia;
Greenwald, Ricky , Mount Sinai School of Medicine, New York, NY, US
Address: Lee, Christopher, 88 Palmerston St., Mosman Park, WAU,
Australia, 6012, chlee@central.murdoch.edu.au
Source: Journal of Clinical Psychology, Vol 58(9), Sep 2002.
pp. 1071-1089.
Publisher: US: John Wiley & Sons.
Abstract: The effectiveness of Stress Inoculation Training with
Prolonged Exposure (SITPE) was compared to Eye Movement Desensitization
and Reprocessing (EMDR). 24 participants (mean age 35.3 yrs) who had a
diagnosis of Post Traumatic Stress Disorder (PTSD) were randomly
assigned to one of the treatment conditions. Participants were also
their own wait-list control. Outcome measures included self-report and
observer-rated measures of PTSD, and self-report measures of depression.
On global PTSD measures, there were no significant differences between
the treatments at the end of therapy. However on the subscale measures
of the degree of intrusion symptoms, EMDR did significantly better than
SITPE. At follow-up EMDR was found to lead to greater gains on all
measures.

Title: Eye movement desensitization and reprocessing: Efficacy with
residential latency-age children.
Author(s): Eckley, Terri Lynn, Alliant International U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering, Vol 63(2-B), Aug 2002. pp. 1021.
Publisher: Transaction Periodicals Consortium, Rutgers
University.
Abstract: This archival study examined the efficacy of EMDR with
residential latency-age children. Participants in the study were the
records of five children who completed a 10-week EMDR treatment
protocol, and four children who were in a control group. Treatment
included art therapy, play therapy, drama therapy, and talk therapy.
EMDR was included as a component of the overall

treatment for the
experimental group. Pre- and post-measures were assessed using the
Behavior Assessment Scale for Children (BASC) and the Trauma Symptom
Checklist for Children (TSCC). Three versions of the BASC were used in
this study: the Parent Rating Scale (PRS), the Teacher Rating Scale
(TRS), and the Self Report of Personality (SRP). Paired-sample t tests
demonstrated significant differences on the BASC-SRP and the TSCC for
the experimental group at pre- and post-measures. For the BASC-SRP, the
children in the experimental group endorsed significantly fewer items
for Atypicality, Locus of Control, Social Stress, and Anxiety at the
conclusion of the study as compared to initial results. For the
experimental group, three of the six scales on the TSCC were
significantly lower at the end of the study than at the beginning of the
study. The children endorsed significantly fewer symptoms of PTSD,
Depression, and Dissociation at the end of treatment as compared to the
beginning of treatment. Because of the numerous limitations of this
study, generalizability is inevitably limited. However, the outcome of
this research indicates that EMDR can be effective to reduce overall
symptomology of severely traumatized children.

Title: Responses of individuals with posttraumatic stress disorder to
eye movement desensitization and reprocessing or a cognitive-behavioral
treatment as mediated by attachment status.
Author(s): Sayer, Peter Clifford , Alliant International U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 63(2-B), Aug 2002. pp. 1047.
Publisher: Transaction Periodicals Consortium, Rutgers
University.
Abstract: The primary focus of this investigation was to evaluate
the responses of individuals diagnosed with Posttraumatic Stress
Disorder (PTSD) to treatment with Eye Movement Desensitization and
Reprocessing (EMDR). In the event that a participant was unable to
tolerate the EMDR approach, an alternative cognitive-behavioral

treatment approach was offered. It was anticipated that individuals
exhibiting Secure Attachment status as revealed on administration of the
Bell Object Relations and Reality Testing Inventory (BORRTI) would
experience lower scores between pre- and post-intervention
administrations of the Symptom Checklist-90-Revised (SCL-90-R). Six
individuals took part in the study; five completed the EMDR protocol and
one completed an alternative cognitive-behavioral therapy program due to
problems tolerating the EMDR treatments. Subjects met with the
researcher/therapist from 1 to 12 sessions, participating in the
assessment, psychoeducational, and treatment components of the protocol.
The application of the BORRTI Insecure Attachment (IA) measure resulted
in five of the participants receiving a designation Secure Attachment
status and one person an Insecure Attachment status classification.
Thus, comparison groups according to attachment status designation could
not be formed. Comparisons of group mean differences between the pre-
and post-intervention administrations of the SCL-90-R did not reveal
statistically significant differences with regard to the five
individuals completing the EMDR protocol. Limitations of the study are
discussed, as well as implications for future research on the mediating
influences of attachment status on the treatment of PTSD.

Title: Eye movement desensitization and reprocessing (EMDR):
Information processing in the treatment of trauma.
Author(s): Shapiro, Francine , Mental Research Inst, Pacific Grove,
CA, US;
Maxfield, Louise, Lakehead U, US
Address: Shapiro, Francine, PO Box 51010, Pacific Grove, CA, US,
93950, fshapiro@emdr.org
Source: Journal of Clinical Psychology, Vol 58(8), Aug 2002.
pp. 933-946.
Publisher: US: John Wiley & Sons.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) is
an efficacious and efficient treatment for posttraumatic stress disorder
(PTSD). This article provides a brief overview of the

findings of 20
controlled-outcome studies and describes F. Shapiro's Adaptive
Information Processing model (2001). This model posits that pathology
results when distressing experiences are processed inadequately and
hypothesizes that EMDR accelerates information processing, resulting in
the adaptive resolution of traumatic memories. A detailed description of
the eight phases of treatment highlights the procedures, assumptions,
and clinical observations that currently guide EMDR clinical practice. A
case study, with an in-session transcript, illustrates the application
of EMDR to address the past events that have laid the groundwork for
dysfunction, the present circumstances that elicit distress, and skills
acquisition needed for adaptive functioning.

Title: "Counterpoint: Emperor's new clothes?": Comment.
Author(s): Spector, John , Watfrod General Hosp, United Kingdom
Source: Psychologist , Vol 15(7), Jul 2002. pp. 335-336.
Publisher: England: British Psychological Society.

Abstract: Addresses S. Joseph's critical commentary (see record
2002-01369-004) on the original article by F. Shapiro and L. Maxfield
which reported on the efficacy of eye movement desensitization and
reprocessing therapy (EMDR). The current author offers support for EMDR,
disputing the validity of Joseph'sclaims that EMDR lacks the appropriate
evidence (in regards to its efficacy) necessary for its professional acceptance.

Title: Support for EMDR: Response.
Author(s): Roberts, Brenda , Hove Polyclinic, Hove, ESX, England
Source: Psychologist , Vol 15(7), Jul 2002. pp. 335.
Publisher: England: British Psychological Society.

Abstract: Responds to the comments by S. Joseph (see record
2002-01369-004) made regarding the original article by F. Shapiro and L.
Maxfield which reported on the clinical applications of eye movement
desensitization and reprocessing therapy (EMDR). Joseph's comment
cautioned against the adoption of EMDR without

the appropriate evidence
to back it up. The current author offers her support for EMDR.

Title: Counterpoint: Emperor's new clothes?
Author(s): Joseph, Stephen, U Warwick, Dept of Psychology,
Coventry, England
Source: Psychologist, Vol 15(5), May 2002. pp. 242-243.
Publisher: England: British Psychological Society.
Abstract: Comments on F. Shapiro and L. Maxfield's (see record
2002-12349-001) discussion of eye movement desensitization and
reprocessing (EMDR). Shapiro and Maxfield state that EMDR is an
effective treatment for posttraumatic stress disorder (PTSD). The
current author discusses whether EMDR is an effective therapy or a
"psuedoscientific repackaging of existing psychotherapeutic factors
dressed up in the emperor's new clothes of eye movements." The current
author supports the latter theory, and cautions against the adoption of
EMDR without the appropriate evidence to back it up.

Title: In the blink of an eye.
Author(s): Shapiro, Francine , EMDR Institute, Pacific Grove, CA,
US;
Maxfield, Louise , Lakehead U, Thunder Bay, ON, Canada
Source: Psychologist, Vol 15(3), Mar 2002. pp. 120-124.
Publisher: England: British Psychological Society.

Abstract: Reports on the clinical applications of eye movement
desensitization and reprocessing therapy (EMDR), on research evaluating
treatment outcomes, and on EMDR's mechanism of action. Empirical
investigations of EMDR indicate that it is the most widely researched
treatment for posttraumatic stress disorder (PTSD). There appears to be
an agreement that EMDR is effective in the treatment of trauma. While
some view it as a cognitive-behavioral treatment (CBT), EMDR's use of
exposure is quite different from basic CBT theories and applications.
EMDR also contains elements from a wide variety of therapeutic
orientations, and it is assumed that these elements actively contribute

to the clinical effects of its integrated approach. While EMDR has been found to be an effective and rapid treatment of PTSD, preliminary reports have indicated its effectiveness with a wide range of experientially based disorders. Research is now under way to evaluate these treatment applications.

Title: The use of eye movement desensitization and reprocessing (EMDR) within a multi-modal treatment program for child victims of extrafamilial sexual abuse.
Author(s): Bermudez, Jose Simon, Carlos Albizu U., US
Source: Dissertation Abstracts International: Section B: The Sciences & Engineering, Vol 63(6-B), Jan 2002. pp. 3000.
Publisher: US: Univ Microfilms International.
Abstract: Sexual abuse has created multiple short and long term problems for many individuals in society today. It often occurs in childhood and the scars that are left can be permanent. Statistically, it occurs with far greater frequency than should be tolerated. However, it is frequently unreported and can be difficult to detect in a child that experiences this form of trauma. There is a significant need to help these children that have been victims of this crime. Extrafamilial sexual abuse in particular appears to occur with greater frequency than intrafamilial sexual abuse. Studies show that it has lasting effects on children. Two of the most common and consistent symptoms seen with these children are post-traumatic stress disorder (PTSD) and sexualized behavior. Other symptoms that have been found with these children include: depression, anxiety, fear, and difficulty managing anger.
Although there have been many program designs implemented for child sexual abuse victims, most do not properly assess the level of improvement through objective measures that show that the treatment was responsible for the observed change and not some other variable. Many different forms of treatment have been used to treat sexual abuse victims, such as different forms of traditional individual therapies, family therapy, group therapy, drama therapy, and

art therapy. One innovative psychotherapeutic technique that has been used recently with these types of clients and those who have experienced other types of traumatic events is Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a relatively new form of treatment developed in 1987 by Francine Shapiro. There have been controlled research studies that have shown the efficacy of this technique. Although there are some researchers who are skeptical of the use of this technique and challenge its effectiveness, studies have nonetheless shown that it is an effective form of brief therapy with long-term effects. This proposed treatment program would be developed for children, aged 6-12 years, who have been victims of extrafamilial sexual abuse. It is designed to be short term, lasting 4 months, and EMDR will be utilized as the primary psychotherapeutic tool to assist the children in reprocessing their traumatic experience. Mental health services that would be provided include individual therapy consisting primarily of EMDR, group therapy for the child and the parents or caretakers provided separately, and family therapy that would include the parents, child, and siblings if deemed necessary. The children admitted to the program would meet criteria for a diagnosis of PTSD. They would also be given psychological measures in order to establish a baseline in terms of current symptoms such as depression and anxiety. The same measures would be administered again at the completion of treatment allowing for the measurement of any improvements. It is expected that children who complete the program would show a significant reduction or elimination of PTSD symptoms. This can be done more effectively by treating the family as a unit in dealing with such a traumatic experience. It is believed that this form of treatment would provide a valuable service to the community and further our understanding regarding the efficacy of EMDR.

Title: EMDR 12 years after its introduction: Past and future research.
Author(s): Shapiro, Francine , Mental Research Inst, Palo Alto, CA,

US
Address: Shapiro, Francine, Box 51010, Pacific Grove, CA, 93950
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 1-22.
Publisher: US: John Wiley & Sons.
Abstract: Notes that Eye Movement Desensitization and Reprocessing (EMDR) was one of the first treatments of posttraumatic stress disorder (PTSD) to be evaluated in controlled research and has to date been empirically supported by 13 such studies. This article reviews the historical context and empirical research of EMDR over the past dozen years. Historically, EMDR's name has caused confusion in that "desensitization' is considered to be only a by-product of reprocessing and because the eye movement component of EMDR is only one form of dual stimulation to be successfully used in this integrative approach. Research is needed to determine the comparative efficacy of EMDR relative to cognitive-behavioral treatments of PTSD. However, it is suggested that this has been hampered by the lack of independent replication studies of the latter treatments. Current component analyses of EMDR have failed to effectively evaluate the relative weighting of its procedures. Parameters for future research and the testing of protocols for diverse disorders are suggested.

Title: The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD.
Author(s): Maxfield, Louise , Lakehead U, Psychology Dept, Thunder Bay, Canada; Hyer, Lee
Address: Maxfield, Louise, Lakehead U, Psychology Dept, 955 Oliver Rd, Thunder Bay, ON, Canada, P78 5E1, jlmaxfie@flash.lakeheadu.ca;
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 23-41.
Publisher: US: John Wiley & Sons.
Abstract: Notes that the controlled treatment outcome studies that examined the efficacy of Eye Movement Desensitization and Reprocessing (EMDR) in the treatment of posttraumatic stress disorder have yielded a range of results, with the efficacy of EMDR varying across studies. The

current study sought to determine if differences in outcome were related
to methodological differences. The research was reviewed to identify
methodological strengths, weaknesses, and empirical findings. The
relationships between effect size and methodology ratings were examined,
using the Gold Standard (GS) Scale (adapted from Foa & Meadows, 1997).
Results indicated a significant relationship between scores on the GS
Scale and effect size, with more rigorous studies according to the GS
Scale reporting larger effect sizes. There was also a significant
correlation between effect size and treatment fidelity. Additional
methodological components not detected by the GS Scale were identified,
and suggestions were made for a Revised GS Scale. We conclude by noting
that methodological rigor removes noise and thereby decreases error
measurement, allowing for the more accurate detection of true treatment
effects in EMDR studies.
Conference: The Association for the Advacement of Behavior Therapy.,
Nov, 1999, Toronto, Canada
Conference Note: The data in this article were presented at the
aforementioned conference and at the International Society for Traumatic
Stress Studies in Miami, FL., Novemeber 1999.

Title: EMDR: A putative neurobiological mechanism of action.
Author(s): Stickgold, Robert, Harvard Medical School, Dept of
Psychiatry, Boston, MA, US
Address: Stickgold, Robert, Harvard Medical School, Dept of
Psychiatry, 74 Fernwood Rd, Boston, MA, US, 02115,
rstickgold@hms.harvard.edu
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 61-75.
Publisher: US: John Wiley & Sons.
Abstract: Notes that F. Shapiro, in her original description of
eye movement desensitization and reprocessing therapy (EMDR), proposed
that its directed eye movements mimic the saccades of rapid eye movement
sleep (REM), but provided no clear explanation of how such mimicry might
lead to clinical improvement. This paper revisits her original proposal
and presents a complete model for how EMDR

could lead to specific improvement in PTSD and related conditions. It is proposed that the repetitive redirecting of attention in EMDR induces a neurobiological state, similar to that of REM sleep, which is optimally configured to support the cortical integration of traumatic memories into general semantic networks. It is suggested that this integration can then lead to a reduction in the strength of hippocampally mediated episodic memories of the traumatic event as well as the memories' associated, amygdala-dependent, negative affect. Experimental data in support of this model are reviewed and possible tests of the model are suggested.

Title: A critical evaluation of current views regarding eye movement desensitization and reprocessing (EMDR): Clarifying points of confusion.
Author(s): Perkins, Byron R. , Private Practive, US;
Rouanzoin, Curtis C.
Address: Perkins, Byron R., 2212 Dupont Dr, Suite I, Irvine, CA, US, 92612, perkinscntr@mindspring.com
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 77-97.
Publisher: US: John Wiley & Sons.
Abstract: Notes that eye movement desensitization and reprocessing (EMDR) is an active psychological treatment for posttraumatic stress disorder (PTSD) that has received widely divergent reactions from the scientific and professional community. This article examines points of confusion in the published literature on EMDR, including the theoretical, empirical, and historical issues around EMDR and placebo effects, exposure procedures, the eye movement component, treatment fidelity issues, and outcome studies. It also examines historical information relevant to the scientific process and charges of "pseudoscience' regarding EMDR. It is concluded that the confusion in the literature is due to (1) the lack of an empirically validated model capable of convincingly explaining the effects of the EMDR method, (2) inaccurate and selective reporting of research, (3) some poorly designed empirical studies, (4) inadequate treatment fidelity

in some outcome
research, and (5) multiple biased or inaccurate reviews by a relatively
small group of authors. It is suggested that reading the original
research articles frequently helps to reduce the confusion arising from
the research review literature.

Title: Brief treatment for elementary school children with
disaster-related posttraumatic stress disorder: A field study.
Author(s): Chemtob, Claude M., Dept of Veterans Affairs, National
Ctr for PTSD, Pacific Islands Div, Honolulu, HI, US; Nakashima, Joanne; Carlson, John G.
Address: Chemtob, Claude M., Dept of Veterans Affairs, National
Ctr for PTSD, Pacific Islands Div, 1132 Bishop St, Suite 307, Honolulu,
HI, US, 96813
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 99-112.
Publisher: US: John Wiley & Sons.
Abstract: Evaluated the effectiveness of a brief intervention for
disaster-related posttraumatic stress disorder (PTSD). At 1-yr follow-up
of a prior intervention for disaster-related symptoms, some previously
treated children were still suffering significant trauma symptoms. Using
a randomized lagged-groups design, 3 sessions of Eye Movement
Desensitization and Reprocessing (EMDR) treatment were provided to 32 of
these children (ages 6-12 yrs) who met clinical criteria for PTSD. The
Children's Reaction Inventory (CRI) was the primary measure of the
treatment's effect on PTSD symptoms. Associated symptoms were measured
using the Revised Children's Manifest Anxiety Scale (RCMAS) and the
Children's Depression Inventory (CDI). Treatment resulted in substantial
reductions in both groups' CRI scores and in significant reductions in
RCMAS and CD1 scores. Gains were maintained at 6-mo follow-up. Health
visits to the school nurse were significantly reduced following
treatment. Psychosocial intervention appears useful for children
suffering disaster-related PTSID. Conducting controlled studies of
children's treatment in the postdisaster environment appears feasible.

Title: Comparison for two treatments for traumatic stress: A community-based study of EMDR and prolonged exposure.
Author(s): Ironson, Gail, U Miami, Cable Gables, FL, US;
Freud, B.; Strauss, J. L.; Williams, J.
Address: Ironson, Gail, U Miami, Behavioral Medicine Program,
P.O. Box 248185, Coral Gables, FL, 33124-2070, gironson@aol.com
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 113-128.
Publisher: US: John Wiley & Sons.
Abstract: This pilot study compared the efficacy of 2 treatments for postraumatic stress disorder (PTSD): Eye Movement Desensitization and Reprocessing (EMDR) and Prolonged Exposure (PE). Data were analyzed for 22 patients (aged 16-62 yrs) from a university based clinic serving the outside community (predominantly rape and crime victims) who completed at least 1 active session of treatment after 3 preparatory sessions. Results showed both approaches produced a significant reduction in PTSD and depression symptoms, which were maintained at 3-month follow-up. Successful treatment was faster with EMDR as a larger number of people (7 of 10) had a 70% reduction in PTSD symptoms after 3 active sessions compared to 2 of 12 with PE. EMDR appeared to be better tolerated as the dropout rate was significantly lower in those randomized to EMDR versus PE (0 of 10 vs 3 of 10). However all patients who remained in treatment with PE had a reduction in PTSD scores. Finally, Subjective Units of Distress (SUDS) ratings decreased significantly during the initial session of EMDR, but changed little during PE. Postsession SUDS were significantly lower for EMDR than for PE. Suggestions for future research are discussed.

Title: Eye movement desensitization and reprocessing in the treatment of post-traumatic stress disorder.
Author(s): Maxfield, Louise , Lakehead U, Canada
Source: Figley, Charles R. (Ed); 2002. Brief treatments for the traumatized: A project of the Green Cross Foundation. Contributions in psychology, no. 39. Westport, CT, US: Greenwood

Press/Greenwood
Publishing Group, Inc. pp. 148-169
Abstract: Since Eye Movement Desensitization and Reprocessing
(EMDR) was introduced 12 years ago (F. Shapiro, 1989), it has become the
most research treatment for posttraumatic stress disorder (PTSD) and its
efficacy has been widely recognized. EMDR is a comprehensive treatment
protocol in which the client attends to emotionally disturbing material
in short sequential doses while simultaneously focusing on an external
stimulus. This chapter provides an overview of the development of EMDR
and Shapiro's (2001) Adaptive Information Processing Model, which
hypothesizes that EMDR works by forging new links between elements of
traumatic memories and adaptive information contained in other memory
networks. The empirical evidence is examined, with summaries of 12
controlled studies: Civilian participants demonstrated a 70-90% decrease
in PTSD diagnosis after 3-4 EMDR sessions. A concise explanation of the
8 phases of EMDR treatment process is augmented with multiple client
vignettes. Finally, a case illustration provides a detailed description
of the application of EMDR in the treatment of PTSD.

Title: Eye movement desensitization and reprogramming (EMDR).
Author(s): Zangwill, William M., EMDR Inst, New York, NY, US;
Pearson, Jessica, Yeshiva U, Ferkauf Graduate School of Psychology,
Bronx, NY, US;
Kosminsky, Phyllis, Ctr for Hope, Darien, CT, US
Source: Shannon, Scott (Ed); 2002. Handbook of complementary and
alternative therapies in mental health. San Diego, CA, US: Academic
Press. pp. 309-330
Abstract: Discusses eye movement desensitization and reprocessing
(EMDR) and its relevance to mental health. Consistent with many
psychological therapies, EMDR assumes that most problems arise from
faulty learning. In EMDR, however, the concept of learning is defined
very broadly. Learning is viewed as a process that is not only
cognitive, but sensory, affective, and physiological as well. This more
holistic view of learning and information processing

is 1 of the factors
that distinguishes EMDR from many other
therapies. Another factor that
differentiates EMDR from other approaches is its
emphasis on the
positive as well as the negative, and not on
pathology. To change
dysfunctional beliefs and reduce irrational fears,
EMDR accesses both
intellectual and emotional informational networks.
As a method of
psychotherapy, EMDR has tremendous relevance
for mental health. It has
proven to reduce pain in a number of areas, but
the primary focus of
EMDR continues to be in the treatment of
posttraumatic stress disorder
(PTSD).

Title: Meta-analysis of Eye Movement
Desensitization and Reprocessing
efficacy studies in the treatment of PTSD.
Author(s): Alto, Caroline, Seton Hall U, Coll
Education And Human
Services, US
Source: Dissertation Abstracts International:
Section B: The
Sciences & Engineering, Vol 62(5-B), Dec 2001. pp.
2474.
Publisher: US: Univ Microfilms International.
Abstract: Eye Movement Desensitization and
Reprocessing (EMDR) is
a relatively new psychological therapy used in the
treatment of
Posttraumatic Stress Disorder (PTSD) and other
disorders. EMDR is unique
in that it combines sets of therapist-administered
eye movements in
conjunction with protocol-driven cognitive and
affective processing
related to past trauma. EMDR has become a
controversial technique for
reasons including a lack of explanation for why it
works and stunning
claims made for its efficacy in the literature.
Despite a large amount
of research over the past decade, EMDR has not
before been studied
meta-analytically in its own right. The present
investigation used
meta-analysis to examine the collection of EMDR
PTSD studies available
in the literature. The literature search resulted in a
total of 21
studies, which met inclusion criteria. These primary
studies in turn
resulted in a collection of 118 effect sizes included
in the analysis.
Two separate analyses were conducted dependent
on whether EMDR was
compared to a no treatment control group or an

alternative treatment
control group. In addition to an overall estimate of the efficacy of
EMDR in the treatment of PTSD represented through an effect size, five
sub-hypotheses were investigated. First, it was hypothesized that RMDR
would be more efficacious with a non-combat population than with
combat-related PTSD. The second sub-hypothesis was that there would be
significantly larger treatment effects associated with verbal report
measures than with physiological outcome measures used in EMDR PTSD
studies. Third, it was hypothesized that earlier EMDR studies would show
larger treatment effects than more recent EMDR studies. The fourth
sub-hypothesis concerned treatment dosage. It was hypothesized that
there would not be significant differences based on the number of
treatment sessions administered. Finally, it was hypothesized that the
bilateral stimulation component of EMDR therapy would not contribute
significantly to treatment effects. The analysis consisted of generating
effect sizes in the form of standardized difference scores on the
various outcome measures. Effect sizes were then grouped according to
independent variable categories and averaged together. Before testing
for between-group differences, homogeneity testing was completed.
(Abstract shortened by UMI.)

Title: Women's trauma and healing in Japanese culture.
Author(s): Muramoto, Kuniko , The Union Inst., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 62(3-B), Sep 2001. pp. 1591.
Publisher: US: Univ Microfilms International.
Abstract: This dissertation explores the reality of women's trauma
and the effective treatment for traumatized women in Japanese culture.
Current research on Post Traumatic Stress Disorder supports the
universality of many of the biologically determined components of PTSD
experiences, while the importance of considering the cultural aspect of
trauma is also stressed. Key research questions were: Can PTSD and
trauma-related disorders be diagnosed in Japanese

women? To what degree
are the trauma theory and treatment methods from the West applicable to
Japanese women? The primary research method was a literature review
supplemented by interviews with Japanese clinicians and reflections on
the author's experience as a psychotherapist. In Japan, the interest in
trauma has been rapidly growing in the 1990s, particularly after the
year 1995 when the Great Hanshin (Kobe) Earthquake happened. The
developing statistics of women's trauma in Japan signify a serious
problem to women's mental health, as is found in United States. Although
the literature is limited yet, the research indicated that Japanese
women suffer almost the same symptoms of PTSD and other trauma-related
symptoms as women in the U.S. One distinctive characteristic is that
Japanese people tend to complain of physical pain rather than
psychological symptoms. The assessment and treatment procedures for
traumatized women were not studied enough in Japan. The author
illustrated the effective assessment and treatment plan for Japanese
women as an example. The Western trauma theories and treatment methods
are applicable to Japanese women, requiring some additional devices.
Supportive psychotherapy and EMDR seem to be prevalent approaches at
present. Creative art therapy and body-centered approaches have the
potential to be effective in Japanese culture. Vicarious traumatization
in mental health professionals is becoming a serious problem in Japan,
too. The author also paid attention to multigenerational trauma in
Japanese society. The trauma caused by World War II is reviewed in an
effort to suggest the enormity of the task we have in dealing with
trauma. It is time for Japanese people to resolve multigenerational
trauma so as to stop continuous trauma and to take care of traumatized
people.

Title: Metaanalyse der Studien zur EMDR-Behandlung von Patienten mit posttraumatischen Belastungs-stoerungen--Der Einfluss der Studienqualitaet auf die Effektstaerken.
Translated Title: Study quality and effect-sizes: A

meta-analysis
of EMDR-treatment for posttraumatic stress disorder.
Author(s): Sack, Martin , Medizinische Hochschule Hannover,
Abteilung Psychosomatik und Psychotherapie, Hannover, Germany;
Lempa, Wolfgang; Lamprecht, Friedhelm
Address: Sack, Martin, Medizinische Hochschule Hannover,
Abteilung Psychosomatik und Psychotherapie, 30625, Hannover, Germany,
sack.martin@mh-hannover.de
Source: Psychotherapie Psychosomatik Medizinische Psychologie ,
Vol 51(9-10), Sep-Oct 2001. pp. 350-355.
Publisher: Germany: Georg Thieme Verlag.
Abstract: This meta-analysis tries to answer the question of
whether eye movement desensitization and reprocessing therapy for
posttraumatic stress disorder (PTSD) studies with higher quality
standards achieve better results than others. Therefore, all published
studies underwent a scoring procedure of study quality and effect sizes
were computed. It was shown that carefully planned studies, including
treatment by well-trained therapists and with a sufficiently high number
of treatment sessions, achieved better results compared to studies with
low methodological standards.

Title: The comparative effects of eye movement desensitization and
reprocessing (EMDR) and cognitive behavioral therapy (CBT) in the
treatment of depression.
Author(s): Hogan, William Andrew , Indiana State U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 62(2-B), Aug 2001. pp. 1082.
Publisher: US: Univ Microfilms International.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) is
a unique, short-term therapy shown to be effective in the treatment of
Posttraumatic Stress Disorder (PTSD). Application of EMDR to the
treatment of depression was considered based upon the relationship
between negative life experience and symptom onset, a pattern common to
both PTSD and depression. Evaluation of the efficacy of EMDR in the
treatment of depression was accomplished via a comparison with cognitive

behavioral therapy (CBT). Because EMDR has been shown to be effective in the treatment of PTSD, the impact of EMDR and CBT upon symptoms comorbid to depression was investigated. EMDR was also compared to CBT assessing the participants' satisfaction. The participants, 15 per treatment group, received either one session of EMDR or cognitive behavioral therapy within the first four sessions. Pre and posttreatment assessment utilized two standardized instruments evaluating self-report of depressive and global symptoms. Participant satisfaction was assessed using a rating scale at posttreatment. Both treatment groups reported significant reductions in depressive symptoms and global symptoms. There were no statistical differences between groups on the symptom measures at posttreatment. Four participants in the EMDR group reported near complete remission of depressive symptoms and large reductions in global symptoms. No participants in the CBT group exhibited this pattern of symptom reduction. Regarding participant satisfaction, participants perceived EMDR to be less negative than CBT primarily due to the increased awareness of negative thoughts common to cognitive behavioral therapy but not experienced in EMDR treatment. The similarity in symptom reduction reported for both groups suggested the undue influence of non-specific treatment effects. The marked remission of symptoms reported by the four participants in the EMDR group parallels the symptom reductions noted in EMDR studies of PTSD.

Title: Eye movement desensitization and reprocessing treatment for posttraumatic stress disorder and other psychological traumas: A decade of research in review.
Author(s): Tye, Jane Ann , United States International U., US
Source: Dissertation Abstracts International: Section B: The Sciences & Engineering , Vol 62(2-B), Aug 2001. pp. 1102.
Publisher: US: Univ Microfilms International.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) is a relatively new complex treatment method that incorporates salient

aspects of many of the major therapeutic modalities as a treatment for posttraumatic stress disorder (PTSD) and other psychological trauma in a civilian population. One of the basic underlying principles is elucidated in the Accelerated Processing Model which posits the ability to access and process dysfunctional perceptions that were stored at the time of the traumatic event. These state-dependent perceptions are considered the primary cause of posttraumatic stress symptomatology. The purpose of this review was to investigate whether the EMDR method is an efficacious treatment for individuals diagnosed with PTSD, as reflected in a critical review of the literature from the initial study conducted in 1989 through 2000. The review included the history and background, development, and research to date of EMDR as a method of treatment for PTSD. A description was provided of the psychometric instruments utilized in the assessment; diagnosis; and measurement of the presence, absence, and level of severity of PTSD symptomatology, as described in the research literature of EMDR. Of special concern was the discrepancy between the diagnostic criteria and the presence, absence, and level of severity of PTSD symptomology as described in the treatment outcomes presented in the literature. Included were criteria for assessment instrument comparison, as well as the current limitations in assessment conformity and methodology which restrict the generalizability and assumptions about the way in which traumatic experiences manifest and influence treatment outcomes.

Title: Stress management with law enforcement personnel: A controlled outcome study of EMDR versus a traditional stress management program.

Author(s): Wilson, Sandra A., Spencer Curtis Foundation, Colorado Springs, CO, US; Tinker, Robert H.; Becker, Lee A.; Logan, Carol R.
Address: Wilson, Sandra A., Spencer Curtis Foundation, 524 North Tejon Street, Colorado Springs, CO, US, 80903, swilson@brain.uccs.edu

Source: International Journal of Stress Management , Vol 8(3), Jul 2001. pp. 179-200.

Publisher: US: Kluwer Academic/Plenum Publishers.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) has been shown to be effective for treating posttraumatic stress disorder (PTSD), but its efficacy as a stress management tool for normal individuals in highly stressful occupations has not been demonstrated. 62 police officers (aged 23-53 yrs old) were randomly assigned to either EMDR or a standard stress management program (SMP), each consisting of 6 hours of individualized contact. At completion, officers in the EMDR condition provided lower ratings on measures of PTSD symptoms, subjective stress, job stress, and anger; and higher marital satisfaction ratings than those in SMP. The effects of EMDR were maintained at the 6-month follow-up, indicating enduring gains from a relatively brief treatment regimen for this subclinical sample of officers who were experiencing some level of stress from their job.

Title: Eye movement desensitisation and reprocessing: A matter for serious consideration?
Author(s): Senior, Jeanette , U York, Dept of Psychology, York, England
Source: Psychologist, Vol 14(7), Jul 2001. pp. 361-363.
Publisher: England: British Psychological Society.
Abstract: Eye movement desensitization and reprocessing (EMDR) has attracted an abundance of scientific interest. It is hailed as a cost-effective and powerful technique for the treatment of posttraumatic stress disorder (PTSD). During its lifetime EMDR has been controversial. Promises of an instant, quick and painless solution to severe PTSD has attracted a wide audience. Despite criticisms, few would disagree that the EMDR movement has grown faster than either the psychoanalytic or the behavior therapy movements. This article sets out to promote thought as to whether treatments that are ineffectually proven might be doing more harm than good. It suggests that branching out into usage of EMDR with conditions other than PTSD might be dangerous until more research points to how it actually works. Moreover, the author wishes to encourage

serious consideration of whether or not eye movements play a part in the treatment's success.

Title: Eye movement desensitization and reprocessing: Innovative clinical applications.
Author(s): Protinsky, Howard , Virginia Tech, Marriage & Family Doctoral Program, Blacksburg, VA, US; Sparks, Jennifer; Flemke, Kimberly
Address: Protinsky, Howard, Virginia Tech, Marriage & Family Doctoral Program, 840 University City Blvd, Ste 1, Blacksburg, VA, US, 24061, hprotins@vt.edu
Source: Journal of Contemporary Psychotherapy, Vol 31(2), Sum 2001. pp. 125-135.
Publisher: US: Kluwer Academic/Plenum Publishers.
Abstract: Neurologically-based therapies such as eye movement desensitization and reprocessing (EMDR) are being clinically implemented and researched in the field of psychotherapy. While EMDR has a theoretical base and some research support for its effectiveness with posttraumatic stress disorder (PTSD) therapists are now developing and using EMDR for other clinical problems. This report illustrates some of the unique applications of EMDR with clinical problems such as: driving phobia, interpersonal arguments, dyspareunia, depression, anxiety, and eating problems.

Title: Eye movement desensitization and reprocessing in the psychological treatment of combat-related guilt: A study of the effects of eye movements.
Author(s): Cerone, Melanie R., Temple U., US
Source: Dissertation Abstracts International: Section B: The Sciences & Engineering, Vol 61(10-B), May 2001. pp. 5555.
Publisher: US: Univ Microfilms International.
Abstract: The purpose of this study was to investigate the role of eye movements in Eye Movement Desensitization and Reprocessing (EMDR), and to test the efficacy of EMDR in the treatment of guilt associated with combat trauma. EMDR was compared to a non-eye movement (NEM) analog, which entailed the full EMDR procedure minus the eye movements.

A single-case multiple component cross-over design across seven participants was utilized. Participants were combat veterans who were receiving inpatient treatment for Posttraumatic Stress Disorder (PTSD) at the Coatesville Veterans Administration Medical Center. Four participants were introduced first to the EMDR condition and three participants were introduced first to the NEM analog condition. Each participant was exposed to both conditions. Dependent measures included: (1) pre- and post-treatment scores on the Clinician Administered PTSD Scale for DSM-IV - One Week Symptom Status Version (CAPS-SX), Beck Depression Inventory (BDI), Impact of Event Scale (IES), and Trauma Related Guilt Inventory (TRGI), (2) self-monitoring data on the frequency and intensity of intrusive thoughts, disturbing dreams, and guilt, and (3) measures of participants' subjective level of distress within sessions and pre- and post-treatment using the Subjective Units of Distress Scale (SUDS). As measured by SUDS ratings, EMDR resulted in a greater decrease in dyphoric affect within-session than the NEM analog. EMDR also resulted in a significant decrease in mean SUDS ratings from pre- to post-treatment. EMDR resulted in significant decreases in combat-related PTSD symptomatology, as measured by pre- and post-treatment scores on the CAPS-SX, BDI, and IES. EMDR also resulted in significant decreases in mean pre- and post-treatment frequency of self-reported intrusive thoughts and mean pre- and post-treatment intensity of intrusive thoughts, disturbing dreams, and guilt. Additionally, EMDR resulted in a significant decrease in pre- and post-treatment scores on one scale and two subscales of the TRGI. No differences in the mean frequency and intensity of self-reported intrusive thoughts, disturbing dreams, and guilt were detected between EMDR and the NEM analog. Results of the present study support the role of eye movements in attaining treatment gains with EMDR. Additionally, this study supports the efficacy of EMDR in the treatment of combat-related guilt.

Title: The use of eye movement desensitization and reprocessing (EMDR)
in the treatment of traumatic stress and complicated mourning:
Psychological and behavioral outcomes.
Author(s): Sprang, Ginny, U Kentucky, Coll of Social Work,
Lexington, KY, US
Address: Sprang, Ginny, U Kentucky, Coll of Social Work,
Lexington, KY, US, 40506-0027,
Sprang@pop.uky.edu
Source: Research on Social Work Practice, Vol 11 (3), May 2001.
pp. 300-320.
Publisher: US: Sage Publications.
Abstract: The purpose of this study was to determine the
differential effects of treatment an a complex of symptomatology that
includes grief, posttraumatic stress disorder (PTSD), anxiety, and
self-esteem by comparing eye movement desensitization and reprocessing
(EMDR) and guided mourning (GM) treatments. Twenty-three EMDR clients
(mean age 42.6 yrs) and 27 GM clients (mean age 39.9 yrs) completed
measures designed to assess psychosocial and behavioral symptoms of loss
before and after treatment and at a 9-month follow-up period. Out of the
five psychosocial measures of distress, four (State Anxiety, Impact of
Event Scale, Index of Self-Esteem, and PTSD) were found to be
significantly altered by type of treatment provided, with EMDR clients
reporting the greatest reduction of PTSD symptoms. Data from the
behavioral measures revealed similar findings.

Title: Eye movement desensitization and reprocessing (EMDR): A
meta-analysis.
Author(s): Davidson, Paul R., Queen's U, Dept of Psychiatry,
Kingston, ON, Canada; Parker, Kevin C. H.
Source: Journal of Consulting & Clinical Psychology, Vol 69(2),
Apr 2001. pp. 305-316.
Publisher: US: American Psychological Assn.
Abstract: Eye movement desensitization and reprocessing (EMDR), a
controversial treatment suggested for posttraumatic stress disorder
(PTSD) and other conditions, was evaluated in a meta-analysis of 34
studies that examined EMDR with a variety of populations and measures.

Process and outcome measures were examined separately, and EMDR showed an effect on both when compared with no treatment and with therapies not using exposure to anxiety-provoking stimuli and in pre-post EMDR comparisons. However, no significant effect was found when EMDR was compared with other exposure techniques. No incremental effect of eye movements was noted when EMDR was compared with the same procedure without them. R. J. DeRubeis and P. Crits-Christoph (1998) noted that EMDR is a potentially effective treatment for noncombat PTSD, but studies that examined such patient groups did not give clear support to this. In sum, EMDR appears to be no more effective than other exposure techniques, and evidence suggests that the eye movements integral to the treatment, and to its name, are unnecessary.

Title: ECEM (Eye Closure Eye Movements): Integrating aspects of EMDR with hypnosis for treatment of trauma.
Author(s): Hollander, Harriet E.; Bender, Sheila S.
Source: American Journal of Clinical Hypnosis, Vol 43(3-4), Jan-Apr 2001. pp. 187-202.
Publisher: US: American Society of Clinical Hypnosis.
Abstract: Addresses distinctions between hypnotic interventions and Eye Movement Desensitizing and Reprocessing (EMDR) and discusses their effect on persons who have symptoms of posttraumatic stress disorder (PTSD). Eye movements in hypnosis and EMDR are considered in terms of the different ways they may affect responses in treatment. A treatment intervention within hypnosis called ECEM (Eye Closure, Eye Movements) is described. ECEM can be used for patients with histories of trauma who did not benefit adequately from either interventions in hypnosis or the EMDR treatment protocol used separately. In ECEM the eye movement variable of EMDR is integrated within a hypnosis protocol to enhance benefits of hypnosis and reduce certain risks of EMDR.

Title: Accessing the power in the patient with hypnosis and EMDR.
Author(s): Bjick, Suzanne
Source: American Journal of Clinical Hypnosis,

Vol 43(3-4),
Jan-Apr 2001. pp. 203-216.
Publisher: US: American Society of Clinical Hypnosis.
Abstract: Notes that both E. Rossi's ideodynamic accessing model
of hypnosis and EMDR are intended to access information stored in the
mind-body system. Some possibilities for effectively using hypnosis and
EMDR in combination are discussed. The similarities and the uniqueness
of each method, both theoretically and in terms of the different
protocols, are compared to provide a rationale for combining them.
Verbatim examples from a clinical case (a woman with posttraumatic
stress disorder (PTSD)) are presented to demonstrate exactly how these
models can be usefully combined in clinical practice.

Title: Recommendations and illustrations for combining hypnosis and
EMDR in the treatment of psychological trauma.
Author(s): Beere, Donald B., Central Michigan U, Dept of
Psychology, Mt Pleasant, MI, US; Simon, Melinda J.;
Welch, Kenneth
Source: American Journal of Clinical Hypnosis, Vol 43(3-4),
Jan-Apr 2001. pp. 217-231.
Publisher: US: American Society of Clinical Hypnosis.
Abstract: Evaluates the combination of hypnotherapy and EMDR.
Three experienced therapists, trained in hypnosis and EMDR, distilled
some tentative hypotheses about the use of hypnosis in EMDR from 15
cases, 2 presented here (a 34-yr-old female with posttraumatic stress
disorder (PTSD) and a 16-yr-old female diagnosed with Atypical
Dissociative Disorder). Both cases focused on resolving traumatic issues
using EMDR. An overview of EMDR is provided, including a discussion
pertaining to its efficacy. Similarities and differences between the 2
treatment techniques are discussed.

Title: The wreathing protocol: The imbrication of hypnosis and EMDR in
the treatment of dissociative identity disorder and other dissociative
responses.
Author(s): Fine, Catherine G.; Berkowitz, Ami S.

Source: American Journal of Clinical Hypnosis, Vol 43(3-4),
Jan-Apr 2001. pp. 275-290.
Publisher: US: American Society of Clinical Hypnosis.
Abstract: Proposes a protocol, called Wreathing Protocol, for the
imbricated use of Eye Movement Desensitization and Reprocessing (EMDR)
and hypnosis in the treatment of dissociative identity disorder (DID),
Dissociative Disorder Not Otherwise Specified and chronic posttraumatic
stress disorder (PTSD). The author maintains that this protocol is
useful to advanced clinicians skilled in both modalities independently.
The sequential steps of the Wreathing Protocol will be described and
illustrated by a clinical vignette on DID. The clinical implications of
the use of the Wreathing Protocol will be discussed in DID as well as
the chronic post traumatic spectrum.

Title: The successful treatment of PTSD through overt cognitive
behavioral therapy in non-responders to EMDR.
Author(s): Devilly, Grant J., U Melbourne, Dept of Criminology,
Melbourne, VIC, US
Source: Behavioural & Cognitive Psychotherapy, Vol 29(1), Jan
2001. pp. 57-70.
Publisher: US: Cambridge Univ Press.
Abstract: This research investigated the efficacy of an operantly
cognitive-behavioural trauma treatment protocol (TTP) in 2 cases that
had previously been treated unsuccessfully with Eye Movement
Desensitization and Reprocessing (EMDR). Ss were a 46-yr-old and a
25-yr-old female with posttraumatic stress disorder (PTSD). In line with
previous research, both participants improved following TTP, to the
extent where one of the participants was asymptomatic at post-treatment
and 3 mo follow-up. These cases also demonstrate the ability of a
cognitive-behavioural intervention to successfully treat childhood
sexual abuse victims later in life.

Title: EMDR: Current developments and review update.
Author(s): Spector, John , Watford Hosp, Shrodells Unit, Watford
Herts, United Kingdom

Address: Spector, John, Watford General Hosp, Shrodells Unit,
Vicarage Road, Watford Herts, United Kingdom, WD1 8HB
Source: Psicoterapia Cognitiva e Comportamentale , Vol 7(1), 2001. pp. 25-34.
Publisher: Italy: Tipografia PIME Editrice Srl.
Abstract: The present article examines the empirical evidence in favour and against Eye Movement Desensitization and Reprocessing (EMDR) as an effective therapeutic method for the treatment of posttraumatic stress disorder (PTSD). In reviewing the current literature on this topic the following points are highlighted: (1) many authors have often used emotive language in attacking EMDR; (2) EMDR incorporates well-established therapeutic principles of exposure, cognitive restructuring and self-control procedures; (3) there is not enough empirical data either to dismiss or support the theoretical basis (eye movements included) of EMDR; (4) EMDR is more than simple exposure; (5) EMDR is probably more rapid than traditional exposure methods; (6) EMDR is an effective treatment method. Each point is addressed in detail and the 3 most recent research papers on EMDR are analytically reviewed.

Title: Eye movement desensitization and reprocessing (EMDR) and the anxiety disorders: Clinical and research implications of an integrated psychotherapy treatment.
Author(s): Shapiro, Francine , Mental Research Inst, Palo Alto, CA, US
Address: Shapiro, Francine, P.O. Box 51010, Pacific Grove, CA, US, 93950
Source: Psicoterapia Cognitiva e Comportamentale , Vol 7(1), 2001. pp. 43-75.
Publisher: Italy: Tipografia PIME Editrice Srl.
Abstract: Four recent, independent, rigorously controlled studies of Eye Movement Desensitization and Reprocessing (EMDR) have reported that 84 to 100% of single trauma victims no longer maintain the posttraumatic stress disorder (PTSD) diagnosis after the equivalent of 3 90-minute sessions. The rapidity of EMDR treatment effects makes many ancillary research opportunities available.

Specifically, the increased number of cases resolved in a relatively short period of time allows investigation of neurophysiological phenomena, patterns of cognitive and emotional processing, component analyses of a large range of procedural factors, and evaluation of the efficacy of application to diverse clinical populations. This article describes the procedures and protocols that are believed to contribute to EMDR's clinical effects and are, therefore, suggested for the EMDR treatment and research of the anxiety disorders. This is particularly relevant given the misconceptions that have abounded due to the unfortunate naming of the procedure after the eye movements, which have proved to be only one of many useful types of stimulation, and only one of many components of this complex, integrated treatment.

Title: How to end the EMDR controversy.
Author(s): McNally, Richard J. , Harvard U, Cambridge, MA, US
Address: McNally, Richard J., Harvard U, Dept of Psychology, 33 Kirkland Street, Cambridge, MA, US, 02138, rjm@wjh.harvard.edu
Source: Psicoterapia Cognitiva e Comportamentale , Vol 7(2), 2001. pp. 153-154.
Publisher: Italy: Tipografia PIME Editrice Srl.
Abstract: Discusses how the controversy concerning eye movement desensitization and reprocessing (EMDR; F. Shapiro, 1995) can be resolved. It is proposed that EMDR advocates must document the efficacy of EMDR with posttraumatic stress disorder (PTSD) patients and must replicate these findings at least once. It is suggested that EMDR theorists should provide a psychologically plausible explanation of the role of eye movements in enhancing the efficacy of exposure therapy.

Title: Eye movement desensitization and reprocessing: Current debates and comparative efficacy.
Author(s): Taylor, Steven, U British Columbia, Dept of Psychiatry, Vancouver, BC, Canada
Address: Taylor, Steven, U British Columbia, Dept of Psychiatry, 2255 Westbrook Mall, Vancouver, BC, Canada, V6T

2A1, taylor@unixg.ubc.ca
Source: Psicoterapia Cognitiva e Comportamentale , Vol 7(2), 2001. pp. 169-178.
Publisher: Italy: Tipografia PIME Editrice Srl.
Abstract: Discusses the conflicting claims about eye movement desensitization and reprocessing (EMDR) presented by an EMDR critic (R. J. McNally, 2001) and an EMDR advocate (J. Spector, 2001). The value of randomized dismantling of certain studies to end the EMDR debate, the main controversial issues regarding the merits of EMDR, and the value of EMDR vs other treatments for posttraumatic stress disorder (PTSD) are examined.

Title: Trauma and adaptive information-processing: EMDR's dynamic and behavioral interface.
Author(s): Shapiro, Francine , Mental Research Inst, Palo Alton, CA, US
Source: Solomon, Marion F. (Ed); Neborsky, Robert J. (Ed); et al; 2001. Short-term therapy for long-term change. New York, NY, US: W. W. Norton & Co, Inc. pp. 112-129
Abstract: Reviews some of the elements of the model the author uses to guide Eye Movement Desensitization Reprocessing (EMDR) practice and a variety of its clinical applications. The author begins with the discussion of the use of EMDR and posttraumatic stress disorder (PTSD). Main topics discussed include the following: (1) diagnostic issues; (2) landmark studies of psychotherapy and behavior therapy in PTSD; (3) empirical research on EMDR and PTSD; (4) differences between EMDR and behavior therapies; (5) adaptive information processing model; (6) interface with the psychodynamic approach; and (7) EMDR and the emergence of self.

Title: Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures (2nd ed.).
Author(s): Shapiro, Francine , Mental Research Inst, Palo Alto, CA, US
Source: 2001. New York, NY, US: Guilford Press. xxiv, 472 pp.
Abstract: This volume provides a guide to Eye Movement

Desensitization and Reprocessing (EMDR), the psychotherapeutic approach developed by Francine Shapiro. EMDR is one of the most widely investigated treatments for posttraumatic stress disorder (PTSD), and many other applications are also being explored. To keep up with this growing body of knowledge, the second edition has been revised to incorporate current neurobiological data, findings from controlled clinical studies, and literature on emerging clinical applications.
Chapters provide background on EMDR's development, theoretical constructs, and possible underlying mechanisms, and present updated protocols and procedures for working with adults and children with a range of presenting problems. Among the many clinical populations for whom the material in this volume has been seen as applicable are survivors of sexual abuse, crime, and combat, as well as sufferers of phobias and other experientially based disorders. Detailed descriptions and transcripts guide the clinician through every stage of therapeutic treatment, from client selection to the administration of EMDR and its integration within a comprehensive treatment plan.
Table of Contents: (Abbreviated)
..Background
..Adaptive information processing: The model as a working hypothesis
..Components of EMDR treatment and basic treatment effects
..Phase One: Client history
..Phases Two and Three: Preparation and assessment
..Phases Four to Seven: Desensitization, installation, body scan, and closure
..Working with abreaction and blocks
..Phase eight: Reevaluation and use of the EMDR standard three-pronged protocol
..Protocols and procedures for special situations
..The cognitive interweave: A proactive strategy for working with challenging clients
..Selected populations
..Theory, research, and clinical implications: Theoretical explanations
..Controlled research
References
Index

Title: Using eye movement desensitization and

reprocessing to treat
complex PTSD in a biracial client.
Author(s): JoAn, Rittenhouse , Private Practice, Las Cruces, NM, US
Source: Cultural Diversity & Ethnic Minority Psychology , Vol
6(4), Nov 2000. pp. 399-408.
Publisher: US: American Psychological Assn/Educational Publishing
Foundation.
Abstract: A biracial client's recovery from posttraumatic stress
disorder (PTSD) through the use of eye movement desensitization and
reprocessing (EMDR) is discussed to illustrate the interaction between
ethnicity and phenotype as well as diagnosis and treatment
considerations. This case explores a woman's experience of
discrimination in and out of her home and her vulnerability to complex
PTSD, and it documents the importance of the therapy focusing on
experiences of discrimination and prejudice as well as abuse. It shows
how the client structures her environment in a personally creative
fashion to include representative features of various aspects of her
identity, by her choice of where and who she teaches as well as how and
with whom she spends her free time.

Title: Treatment of PTSD: Stress Inoculation Training with Prolonged
Exposure compared to EMDR.
Author(s): Lee, Christopher , Sir Charles Gairdner Hosp, QEII
Medical Ctr, Perth, Australia;
Gavriel, Helen, HMAS Stirling, Royal Australian Navy, Australia;
Drummond, Peter, Murdoch U, School of Psychology, Perth, Australia;
Richards, Jeff, U Ballarat, Ballarat, Australia;
Greenwald, Ricky , Mount Sinai School of Medicine, New York, NY, US
Address: Lee, Christopher, 88 Palmerston St., Mosman Park, WAU,
Australia, 6012, chlee@central.murdoch.edu.au
Source: Journal of Clinical Psychology, Vol 58 (9), Sep 2002.
pp. 1071-1089.
Publisher: US: John Wiley & Sons.
Abstract: The effectiveness of Stress Inoculation Training with
Prolonged Exposure (SITPE) was compared to Eye Movement Desensitization
and Reprocessing (EMDR). 24 participants (mean age 35.3 yrs) who had a
diagnosis of Post Traumatic Stress Disorder (PTSD)

were randomly
assigned to one of the treatment conditions. Participants were also
their own wait-list control. Outcome measures included self-report and
observer-rated measures of PTSD, and self-report measures of depression.
On global PTSD measures, there were no significant differences between
the treatments at the end of therapy. However on the subscale measures
of the degree of intrusion symptoms, EMDR did significantly better than
SITPE. At follow-up EMDR was found to lead to greater gains on all
measures.

Title: Eye movement desensitization and reprocessing: Efficacy with
residential latency-age children.
Author(s): Eckley, Terri Lynn , Alliant International U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 63(2-B), Aug 2002. pp. 1021.
Publisher: Transaction Periodicals Consortium, Rutgers
University.
Abstract: This archival study examined the efficacy of EMDR with
residential latency-age children. Participants in the study were the
records of five children who completed a 10-week EMDR treatment
protocol, and four children who were in a control group. Treatment
included art therapy, play therapy, drama therapy, and talk therapy.
EMDR was included as a component of the overall treatment for the
experimental group. Pre- and post-measures were assessed using the
Behavior Assessment Scale for Children (BASC) and the Trauma Symptom
Checklist for Children (TSCC). Three versions of the BASC were used in
this study: the Parent Rating Scale (PRS), the Teacher Rating Scale
(TRS), and the Self Report of Personality (SRP). Paired-sample t tests
demonstrated significant differences on the BASC-SRP and the TSCC for
the experimental group at pre- and post-measures. For the BASC-SRP, the
children in the experimental group endorsed significantly fewer items
for Atypicality, Locus of Control, Social Stress, and Anxiety at the
conclusion of the study as compared to initial results. For the

experimental group, three of the six scales on the TSCC were
significantly lower at the end of the study than at the beginning of the
study. The children endorsed significantly fewer symptoms of PTSD,
Depression, and Dissociation at the end of treatment as compared to the
beginning of treatment. Because of the numerous limitations of this
study, generalizability is inevitably limited. However, the outcome of
this research indicates that EMDR can be effective to reduce overall
symptomology of severely traumatized children.

Title: The use of eye movement desensitization and reprocessing (EMDR)
within a multi-modal treatment program for child victims of
extrafamilial sexual abuse.
Author(s): Bermudez, Jose Simon , Carlos Albizu U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 63(6-B), Jan 2002. pp. 3000.
Publisher: US: Univ Microfilms International.
Abstract: Sexual abuse has created multiple short and long term
problems for many individuals in society today. It often occurs in
childhood and the scars that are left can be permanent. Statistically,
it occurs with far greater frequency than should be tolerated. However,
it is frequently unreported and can be difficult to detect in a child
that experiences this form of trauma. There is a significant need to
help these children that have been victims of this crime. Extrafamilial
sexual abuse in particular appears to occur with greater frequency than
intrafamilial sexual abuse. Studies show that it has lasting effects on
children. Two of the most common and consistent symptoms seen with these
children are post-traumatic stress disorder (PTSD) and sexualized
behavior. Other symptoms that have been found with these children
include: depression, anxiety, fear, and difficulty managing anger.
Although there have been many program designs implemented for child
sexual abuse victims, most do not properly assess the level of
improvement through objective measures that show that the treatment was
responsible for the observed change and not some

other variable. Many different forms of treatment have been used to treat sexual abuse victims, such as different forms of traditional individual therapies, family therapy, group therapy, drama therapy, and art therapy. One innovative psychotherapeutic technique that has been used recently with these types of clients and those who have experienced other types of traumatic events is Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a relatively new form of treatment developed in 1987 by Francine Shapiro. There have been controlled research studies that have shown the efficacy of this technique. Although there are some researchers who are skeptical of the use of this technique and challenge its effectiveness, studies have nonetheless shown that it is an effective form of brief therapy with long-term effects. This proposed treatment program would be developed for children, aged 6-12 years, who have been victims of extrafamilial sexual abuse. It is designed to be short term, lasting 4 months, and EMDR will be utilized as the primary psychotherapeutic tool to assist the children in reprocessing their traumatic experience. Mental health services that would be provided include individual therapy consisting primarily of EMDR, group therapy for the child and the parents or caretakers provided separately, and family therapy that would include the parents, child, and siblings if deemed necessary. The children admitted to the program would meet criteria for a diagnosis of PTSD. They would also be given psychological measures in order to establish a baseline in terms of current symptoms such as depression and anxiety. The same measures would be administered again at the completion of treatment allowing for the measurement of any improvements. It is expected that children who complete the program would show a significant reduction or elimination of PTSD symptoms. This can be done more effectively by treating the family as a unit in dealing with such a traumatic experience. It is believed that this form of treatment would provide a valuable service to the community and further our understanding regarding the efficacy of EMDR.

Title: Brief treatment for elementary school children with
disaster-related posttraumatic stress disorder: A field study.
Author(s): Chemtob, Claude M. , Dept of Veterans Affairs, National
Ctr for PTSD, Pacific Islands Div, Honolulu, HI, US; Nakashima, Joanne;
Carlson, John G.
Address: Chemtob, Claude M., Dept of Veterans Affairs, National
Ctr for PTSD, Pacific Islands Div, 1132 Bishop St, Suite 307, Honolulu,
HI, US, 96813
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 99-112.
Publisher: US: John Wiley & Sons.
Abstract: Evaluated the effectiveness of a brief intervention for
disaster-related posttraumatic stress disorder (PTSD). At 1-yr follow-up
of a prior intervention for disaster-related symptoms, some previously
treated children were still suffering significant trauma symptoms. Using
a randomized lagged-groups design, 3 sessions of Eye Movement
Desensitization and Reprocessing (EMDR) treatment were provided to 32 of
these children (ages 6-12 yrs) who met clinical criteria for PTSD. The
Children's Reaction Inventory (CRI) was the primary measure of the
treatment's effect on PTSD symptoms. Associated symptoms were measured
using the Revised Children's Manifest Anxiety Scale (RCMAS) and the
Children's Depression Inventory (CDI). Treatment resulted in substantial
reductions in both groups' CRI scores and in significant reductions in
RCMAS and CD1 scores. Gains were maintained at 6-mo follow-up. Health
visits to the school nurse were significantly reduced following
treatment. Psychosocial intervention appears useful for children
suffering disaster-related PTSID. Conducting controlled studies of
children's treatment in the postdisaster environment appears feasible.

Title: Comparison for two treatments for traumatic stress: A
community-based study of EMDR and prolonged exposure.
Author(s): Ironson, Gail , U Miami, Cable Gables, FL, US; Freud, B.;

Strauss, J. L.; Williams, J.
Address: Ironson, Gail, U Miami, Behavioral Medicine Program,
P.O. Box 248185, Coral Gables, FL, 33124-2070, gironson@aol.com
Source: Journal of Clinical Psychology, Vol 58(1), Jan 2002.
pp. 113-128.
Publisher: US: John Wiley & Sons.
Abstract: This pilot study compared the efficacy of 2 treatments
for postraumatic stress disorder (PTSD): Eye Movement Desensitization
and Reprocessing (EMDR) and Prolonged Exposure (PE). Data were analyzed
for 22 patients (aged 16-62 yrs) from a university based clinic serving
the outside community (predominantly rape and crime victims) who
completed at least 1 active session of treatment after 3 preparatory
sessions. Results showed both approaches produced a significant
reduction in PTSD and depression symptoms, which were maintained at
3-month follow-up. Successful treatment was faster with EMDR as a larger
number of people (7 of 10) had a 70% reduction in PTSD symptoms after 3
active sessions compared to 2 of 12 with PE. EMDR appeared to be better
tolerated as the dropout rate was significantly lower in those
randomized to EMDR versus PE (0 of 10 vs 3 of 10). However all patients
who remained in treatment with PE had a reduction in PTSD scores.
Finally, Subjective Units of Distress (SUDS) ratings decreased
significantly during the initial session of EMDR, but changed little
during PE. Postsession SUDS were significantly lower for EMDR than for
PE. Suggestions for future research are discussed.

Title: The comparative effects of eye movement desensitization and
reprocessing (EMDR) and cognitive behavioral therapy (CBT) in the
treatment of depression.
Author(s): Hogan, William Andrew , Indiana State U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 62(2-B), Aug 2001.
pp. 1082.
Publisher: US: Univ Microfilms International.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) is
a unique, short-term therapy shown to be effective in the treatment of

Posttraumatic Stress Disorder (PTSD). Application of EMDR to the treatment of depression was considered based upon the relationship between negative life experience and symptom onset, a pattern common to both PTSD and depression. Evaluation of the efficacy of EMDR in the treatment of depression was accomplished via a comparison with cognitive behavioral therapy (CBT). Because EMDR has been shown to be effective in the treatment of PTSD, the impact of EMDR and CBT upon symptoms comorbid to depression was investigated. EMDR was also compared to CBT assessing the participants' satisfaction. The participants, 15 per treatment group, received either one session of EMDR or cognitive behavioral therapy within the first four sessions. Pre and posttreatment assessment utilized two standardized instruments evaluating self-report of depressive and global symptoms. Participant satisfaction was assessed using a rating scale at posttreatment. Both treatment groups reported significant reductions in depressive symptoms and global symptoms. There were no statistical differences between groups on the symptom measures at posttreatment. Four participants in the EMDR group reported near complete remission of depressive symptoms and large reductions in global symptoms. No participants in the CBT group exhibited this pattern of symptom reduction. Regarding participant satisfaction, participants perceived EMDR to be less negative than CBT primarily due to the increased awareness of negative thoughts common to cognitive behavioral therapy but not experienced in EMDR treatment. The similarity in symptom reduction reported for both groups suggested the undue influence of non-specific treatment effects. The marked remission of symptoms reported by the four participants in the EMDR group parallels the symptom reductions noted in EMDR studies of PTSD.

Title: Eye movement desensitization and reprocessing: Innovative clinical applications.
Author(s): Protinsky, Howard , Virginia Tech, Marriage & Family Doctoral Program, Blacksburg, VA, US; Sparks,

Jennifer; Flemke, Kimberly
Address: Protinsky, Howard, Virginia Tech, Marriage & Family
Doctoral Program, 840 University City Blvd, Ste 1, Blacksburg, VA, US,
24061, hprotins@vt.edu
Source: Journal of Contemporary Psychotherapy, Vol 31(2), Sum
2001. pp. 125-135.
Publisher: US: Kluwer Academic/Plenum Publishers.
Abstract: Neurologically-based therapies such as eye movement
desensitization and reprocessing (EMDR) are being clinically implemented
and researched in the field of psychotherapy. While EMDR has a
theoretical base and some research support for its effectiveness with
posttraumatic stress disorder (PTSD) therapists are now developing and
using EMDR for other clinical problems. This report illustrates some of
the unique applications of EMDR with clinical problems such as: driving
phobia, interpersonal arguments, dyspareunia, depression, anxiety, and
eating problems.

Title: Eye movement desensitization and reprocessing in the
psychological treatment of combat-related guilt: A study of the effects
of eye movements.
Author(s): Cerone, Melanie R. , Temple U., US
Source: Dissertation Abstracts International: Section B: The
Sciences & Engineering , Vol 61(10-B), May 2001. pp. 5555.
Publisher: US: Univ Microfilms International.
Abstract: The purpose of this study was to investigate the role of
eye movements in Eye Movement Desensitization and Reprocessing (EMDR),
and to test the efficacy of EMDR in the treatment of guilt associated
with combat trauma. EMDR was compared to a non-eye movement (NEM)
analog, which entailed the full EMDR procedure minus the eye movements.
A single-case multiple component cross-over design across seven
participants was utilized. Participants were combat veterans who were
receiving inpatient treatment for Posttraumatic Stress Disorder (PTSD)
at the Coatesville Veterans Administration Medical Center. Four
participants were introduced first to the EMDR condition and three
participants were introduced first to the NEM

analog condition. Each participant was exposed to both conditions. Dependent measures included: (1) pre- and post-treatment scores on the Clinician Administered PTSD Scale for DSM-IV - One Week Symptom Status Version (CAPS-SX), Beck Depression Inventory (BDI), Impact of Event Scale (IES), and Trauma Related Guilt Inventory (TRGI), (2) self-monitoring data on the frequency and intensity of intrusive thoughts, disturbing dreams, and guilt, and (3) measures of participants' subjective level of distress within sessions and pre- and post-treatment using the Subjective Units of Distress Scale (SUDS). As measured by SUDS ratings, EMDR resulted in a greater decrease in dyphoric affect within-session than the NEM analog. EMDR also resulted in a significant decrease in mean SUDS ratings from pre- to post-treatment. EMDR resulted in significant decreases in combat-related PTSD symptomatology, as measured by pre- and post-treatment scores on the CAPS-SX, BDI, and IES. EMDR also resulted in significant decreases in mean pre- and post-treatment frequency of self-reported intrusive thoughts and mean pre- and post-treatment intensity of intrusive thoughts, disturbing dreams, and guilt. Additionally, EMDR resulted in a significant decrease in pre- and post-treatment scores on one scale and two subscales of the TRGI. No differences in the mean frequency and intensity of self-reported intrusive thoughts, disturbing dreams, and guilt were detected between EMDR and the NEM analog. Results of the present study support the role of eye movements in attaining treatment gains with EMDR. Additionally, this study supports the efficacy of EMDR in the treatment of combat-related guilt.

Title: EDMR--Cognitive behavioral method for posttraumatic stress disorder in torture victims.
Author(s): Ilic, Zoran , Inst for Mental Health, Stress Clinic, Belgrade, Yugoslavia; Lecic-Tosevski, Dusica; Bokonjic, Srdjan; Drakulic, Bogdan; Jovic, Vladimir
Source: Psihijatrija Danas , Vol 31(2-3), 1999. pp. 245-258.

Publisher: Yugoslavia: Instituta Za Mentalno Zdravlje.
Abstract: Discusses the theoretical concept of the cognitive-behavioral method of Eye Movement Desensitization and Reprocessing (EMDR). The authors describe the use of EMDR as consisting of 8 phases: the patient's anamnesis and treatment planning, preparing the patient, assessment, desensitization, installation, scanning of the body, and closing. The case of a 44-yr-old male with symptoms of posttraumatic stress disorder (PTSD) associated with depressive symptoms who was treated with EMDR is presented. Two mo after EMDR, the S had no clinical manifestations of PTSD and he did not have them at the repeated test examination, so resocialization started aimed at the reduction of avoidance symptoms.

Title: Eye movement desensitization and reprocessing: Evaluating its effectiveness in reducing trauma symptoms in adult female survivors of childhood sexual abuse.
Author(s): Edmond, Tonya Elaine, U Texas at Austin, US
Source: Dissertation Abstracts International Section A: Humanities & Social Sciences, Vol 59(2-A), Aug 1998. pp. 0617.
Publisher: US: University Microfilms International.
Abstract: The purpose of the study was to evaluate, through the use of a randomized experimental design, the effectiveness of EMDR in reducing trauma symptoms in adult female survivors of childhood sexual abuse. No EMDR research to date has been exclusively comprised of adult survivors of childhood sexual abuse, a historically difficult treatment population. Additionally, while numerous clinical accounts of treatment with sexual abuse survivors have been published, controlled treatment research has rarely been done. Of the studies found that examine treatment efficacy exclusively with this population, none involved the use of random assignment. A sample of sixty adult female sexual abuse survivors were selected and randomly assigned to one of three groups: (1) individual EMDR treatment; (2) individual eclectic treatment; or (3) delayed treatment control group. The participating survivors' trauma

symptoms were measured in pretests and posttests on standardized as well as subjective instruments that measured anxiety, posttraumatic stress, depression, negative beliefs about the sexual abuse, emotional distress and desired positive self beliefs. The survivors' in the study assigned to the experimental or comparison treatment groups received six 90 minute individual sessions of either EMDR or eclectic therapy. The delayed treatment control group subjects were pretested, asked to delay treatment for six weeks, and after being post tested were assigned a therapist with which to work. Data analysis consisted primarily of multivariate and univariate analysis of variance. The posttest results indicated that EMDR was very effective in reducing the targeted trauma symptoms compared to the control group. Eclectic therapy at posttest was also found to be very effective, resulting in a lack of statistically significant differences between the experimental and comparison treatments. However, analysis conducted at the three month follow-up revealed that EMDR was significantly more effective than eclectic therapy at maintaining therapeutic gains. The results of this study suggest that while both EMDR and eclectic therapy, when applied as brief psychotherapy models of treatment for survivors, can produce significant alleviation of trauma symptoms, EMDR may provide more enduring resolution. These findings have important implications for both survivors and the service providers available to them.

Title: EMDR terms and procedures: Resolution of uncomplicated depression.
Author(s): Manfield, Philip
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook of innovative applications. New York, NY, US: W. W. Norton & Co, Inc. pp. 15-36
Abstract: This chapter presents an example of a relatively uncomplicated eye movement desensitization and reprocessing (EMDR) treatment, which can provide a basis for understanding the more complex aspects of cases. The Ss was a man in his 40s with

depression who
completed 9 sessions of EMDR to help the client focus on sources of
disturbing affect, maladaptive world views, and negative
self-perceptions, desensitizing these and processing them in an
accelerated way until an adaptive resolution was achieved. The EMDR
process involved identifying targets for EMDR, identifying an image or
memory that elicits comfortable feelings, desensitization to the target,
and the cognitive interweave process of providing the client with
information that the client has not linked to the target. /// In the
treatment described, the S's depression completely lifted and he was
able to deal more comfortably with problems. After 2 yrs, the results
achieved during these 9 sessions had endured.

Title: Postpartum depression: Helping a new mother to bond.
Author(s): Parnell, Laurel , California Inst of Integral Studies,
San Francisco, CA, US
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook
of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 37-64
Abstract: Presents the case of a new mother who suffered from
acute postpartum depression and was unable to bond with or care for her
new baby. The case demonstrates how a therapist can integrate eye
movement desensitization and reprocessing (EMDR) with dreams, imagery,
and inner child work in intensive brief therapy. The S was a previously
high-functioning woman with obsessive-compulsive tendencies who began to
suffer from psychotic-like thoughts and postpartum depression. The
therapist worked with the S over 4 wks. The 1st sessions focused on
history-taking, assessment, stabilization, anxiety reduction, and
development of a trusting relationship. Relaxation and inner child work
were used to help ease the S's distress. The initial EMDR session was
also used primarily for anxiety reduction. Subsequent EMDR sessions were
more focused to developed targets that included disturbing images,
emotions, body sensations, and negative connotations. The S's symptoms

began to diminish rapidly following EMDR sessions, culminating in a
significant improvement in functioning. EMDR helped the S to distinguish
what was in the past and what was in the present and facilitated an
integration of the previously split-off self-constructs of good girl and
bad girl.

Title: Filling the void: Resolution of a major depression.
Author(s): Manfield, Philip
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook
of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 113-137
Abstract: Presents the case of a 36-yr-old woman who was treated
with eye movement desensitization and reprocessing (EMDR) for major
depression that occurred after surgery for the removal of a large benign
growth next to her stomach. Although the S's immediate complaint was
depression, she was also continuing to encounter life-long difficulties
in her relationships and career choices. This case demonstrates the
value of EMDR in rapidly resolving major depression by processing a
series of traumatic memories. The themes of loss, overwhelming
helplessness, and inadequacy weave through each of these memories and
tie them together. Although major depression is not one of the diagnoses
typically thought of as responsive to EMDR, this case shows the breadth
of change the S experienced as a result of processing traumatic memories
and follow-up integrative work. EMDR helped relieve the depression and a
cluster of other issues that appeared to be more characterological.

Title: Imaginary crimes: Resolving survivor guilt and writer's block.
Author(s): Engel, Lewis , Private Practice, San Francisco, CA, US
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook
of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 138-163
Abstract: Presents the case of a 45-yr-old female with depression,
obsessions about an ex-boyfriend, and writing block who was treated with

control mastery theory that used eye movement desensitization and reprocessing (EMDR) as an exploratory tool and treatment method. Issues of survivor guilt toward her murdered sister, identification with her anxious, unhappy mother, and compliance with her critical and rejecting father were addressed and at least partially worked through in the first 11 sessions of treatment. The S's depression has lifted, she has been able to write freely, and she has stopped obsessing about her ex-boyfriend. The therapist was able to combine cognitive mastery theory and EMDR to create a rapid but deep exploration and amelioration of the client's major, longstanding life problems.

Title: Healing hidden pain: Resolving the effects of childhood abuse and neglect.
Author(s): Vogelmann-Sine, Silke
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 167-190
Abstract: Presents the case of a woman who was treated with eye movement desensitization and reprocessing (EMDR) for major depression and the remembered trauma of childhood abuse and neglect. The case demonstrates that EMDR is a tool that can help clients go back in time and develop those parts of their personalities that could not emerge because of an invalidating environment. EMDR allowed the S to access dissociated feelings and memories from her past. Over time, the S reprocessed the pain experienced in her childhood and was freed to perceive the world from an adult point of view. Her trauma recovery allowed her to be more in touch with her feelings, to believe that the world was a safer place, and to acquire self-worth.

Title: "Am I Real?": Mobilizing inner strength to develop a mature identity.
Author(s): Lovett, Joan
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook of innovative applications. New York, NY, US: W. W. Norton & Co, Inc.
pp. 191-216

Abstract: Presents the case of a 44-yr-old woman who had extremely low self-esteem, depression, panic attacks, and symptoms of dissociation when she began eye movement desensitization and reprocessing (EMDR) therapy. Eye movement was used initially to reinforce healthy beliefs, physical sensations, and feelings related to experiences of safety, competence, well-being, and success based on prior learning. EMDR was then employed to target painful memories of childhood scenes with her parents, as well as erroneous beliefs and feelings of intense anxiety. Although none of the memories targeted occurred before age 5, the empty feeling that was targeted seemed to represent an earlier deprivation. The desired positive cognition "I am significant" became an umbrella cognition containing various sub-cognitions (e.g., "I am lovable"). As the S reprocessed traumatic childhood memories with EMDR, more of these sub-cognitions were integrated. Reprocessing the client's issues as she presented them led to a more stable, flexible, and resilient sense of self.

Title: Lifing the burden of shame: Using EMDR resource installation to resolve a therapeutic impasse.
Author(s): Leeds, Andrew M.
Source: Manfield, Philip (Ed); 1998. Extending EMDR: A casebook of innovative applications. New York, NY, US: W. W. Norton & Co, Inc. pp. 256-281
Abstract: Presents a case of a woman with depression and social isolation, a debilitating physical illness, and a history of childhood abuse and neglect. In this case, eye movement desensitization and reprocessing (EMDR) was used as a resource installation to resolve a therapeutic impasse and to help the client overcome feelings of shame. The author discusses the initiation of EMDR treatment, emotional flooding and a failed early installation, countertransference and demand characteristics, and integrating the use of imaginal resources in posttraumatic stress disorder (PTSD) EMDR protocols. The author also describes the scientific foundations for the use of imaginal resources

and sources for principles used in resource installation.

Title: Extending EMDR: A casebook of innovative applications.
Author(s): Manfield, Philip , (Ed)
Source: 1998. New York, NY, US: W. W. Norton & Co, Inc. xii, 292 pp.
Abstract: Explores the use of eye movement sensitization and reprocessing (EMDR) in the treatment of residual psychological effects of a single-incident trauma, long-term childhood abuse,and complex posttraumatic stress disorder (PTSD). The eleven case reports provided illustrate the application of EMDR to a broad range of cases. The introduction includes basic descriptions of EMDR and the accelerated information processing model, as well as definitions of its terminology. Each of the following chapters begins with a discussion of the contributor's background, the principles of the traditional treatment approach used before incorporating EMDR, and the way he or she has integrated EMDR into that approach. The book is divided into two parts: those cases in which it was possible to target a relatively small number of distinct traumatic experiences, and those in which the clients' symptoms have resulted from ongoing childhood trauma or neglect for which they are unable to identify representative discrete trauma. The description of the client's treatment and progress is detailed enough to enable the reader to understand how the results were achieved. Finally, the duration and outcome of each case are evaluated.
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Title: Controlled study of treatment of PTSD using EMDR in an HMO
setting.
Author(s): Marcus, Steven V., The Permanente Medical Group, Inc.,
Dept of Psychiatry, Santa Clara, CA, US; Marquis, Priscilla;
Sakai, Caroline
Source: Psychotherapy: Theory, Research, Practice, Training ,
Vol 34(3), Fal 1997. pp. 307-315.
Publisher: US: Div of Psychotherapy APA.
Abstract: 67 individuals (aged 18-73 yrs) diagnosed with
posttraumatic stress disorder (PTSD) were randomly assigned to either
Eye Movement Desensitization and Reprocessing (EMDR) treatment or
Standard Care (SC) treatment. Participants were assessed pretreatment,
after 3 sessions, and at the completion of treatment using the SCL-90,
Beck Depression Inventory, Impact of Event Scale (M. Horowitz et al,

1979), modified PTSD Symptom Scale (S. A. Falsetti et al, 1993), State Trait Anxiety Inventory, and other measures. In addition, an independent evaluator assessed participants using Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) criteria for PTSD including Global Assessment of Functioning at the 3 data points. Ss in the EMDR treatment group showed significantly greater improvement with greater rapidity than those in the SC treatment group on measures of PTSD, depression, anxiety, and general symptoms. Ss who received EMDR treatment used fewer medication appointments for their psychological symptoms and needed fewer psychotherapy appointments.

Title: A controlled study of eye movement desensitization and reprocessing in the treatment of posttraumatic stress disordered sexual assault victims.
Author(s): Rothbaum, Barbara Olasov, Emory U, School of Medicine, Dept of Psychiatry & Behavioral Sciences, Atlanta, GA, US
Source: Bulletin of the Menninger Clinic, Vol 61 (3), Sum 1997. pp. 317-334. Publisher: US: Menninger Foundation.
Abstract: Eye movement desensitization and reprocessing (EMDR) is a new method developed to treatment posttraumatic stress disorder (PTSD). This study evaluated the efficacy of EMDR compared to a no-treatment wait-list control in the treatment of PTSD in adult female sexual assault victims. 21 Ss entered the study, and 18 completed the study. Treatment was delivered in 4 weekly individual sessions. Assessments were conducted pre- and posttreatment and 3 mo following treatment termination by an independent assessor kept blind to treatment condition. Results indicate that Ss treated with EMDR improved significantly more on PTSD and depression from pre- to posttreatment than control Ss.

Title: Eye movement desensitization and reprocessing: A multiple baseline study.
Author(s): Zeper, Robbi Schlaffman , The Union

Inst, US
Source: Dissertation Abstracts International: Section B: The Sciences & Engineering , Vol 57(8-B), Feb 1997. pp. 5350.
Publisher: US: Univ Microfilms International.
Abstract: Eye Movement Desensitization and Reprocessing (EMDR) was developed in 1987 by Francine Shapiro, as a modality for relieving anxiety, traumatic memories, intrusive thoughts, and reprocessing negative self-beliefs to positive self-beliefs. One of the most common uses of EMDR in recent years has been the treatment of Post Traumatic Stress Disorder (PTSD). This current study investigated the effects of EMDR across a sample of 3 sexually abused women diagnosed with PTSD using a multiple baseline design across subjects. The study specifically focused on whether or not intervention with EMDR effects traumatic memory and negative/irrational cognitions, decreases stress or changes levels of anxiety, depression and heart rate. The study intended to assess the efficacy of EMDR while simultaneously reduce human suffering and answer some of the more serious criticisms which have blurred confidence in EMDR outcome research. Specifically, the study controlled for a number of the criticisms in the literature predominantly through a confirmation of an accurate PTSD diagnosis and through the use of a multiple baseline design. The multiple baseline design was applied sequentially to the same problem across different but matched subjects sharing the same environmental conditions. Heart rate level and well-known psychometrics were used to obtain baseline, intervention and post-intervention measures. Psychometric scores reflecting levels of depression, anxiety, and subjective levels of the impact of distress regarding the trauma were assessed along with the levels of anxiety currently experienced about the trauma and subjective ratings regarding the acceptance of the preferred, self-generated positive cognition. The measures used in this study were an initial clinical interview, an Anxiety Disorders Interview Schedule for the DSM IV (Brown, DiNardo & Barlow, 1994), Beck Depression Inventory (Beck, Rush, Shaw & Emery,

1979), Beck Anxiety Inventory (Beck, 1993), Wolpe's Subjective Unit of

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Translated Title: Eye movement desensitization and reprocessing
(EMDR) treatment for combat-related posttraumatic stress disorder.
Author(s): Carlson, John G., U Hawaii at Manoa, Dept of
Psychology, Honolulu, HI, US; Chemtob, Claude M.; Rusnak, Kristin;
Hedlund, Nancy L.; Muraoka, Miles Y.
Source: Japanese Journal of Biofeedback Research, Vol 24, 1997.
pp. 50-64.
Publisher: Japan: Japanese Society of Biofeedback Research.
Abstract: Studied the efficacy of eye movement desensitization and
reprocessing (EMDR) treatment for combat-related posttraumatic stress
disorder (PTSD). Human Ss: 35 male American adults (aged 41-70 yrs)
(PTSD) (34 Vietnam War veterans and 1 Korean War veteran). Tests used:
The Clinician Administered PTSD Scale (D. D. Blake et al, 1995), the
restandardized MMPI, the Mississippi Scale for Combat Related PTSD (T.
M. Keane et al, 1988), the State-Trait Anxiety Inventory, the Beck
Depression Inventory, the Impact of Events Scale and the Initial
Screening Questionnaire. Treatments: 10 Ss were administered 12 EMDR
sessions, 13 Ss were administered 12 sessions of biofeedback and
relaxation, and 12 Ss were administered standard treatment.

Title: EMDR: The breakthrough therapy for overcoming anxiety, stress,
and trauma.
Author(s): Shapiro, Francine, Mental Research Inst, Palo Alto, CA,
US; Forrest, Margot Silk
Source: 1997. New York, NY, US: Basic Books, Inc. xii, 285 pp.
Abstract: EMDR (Eye Movement Desensitization and Reprocessing) is
the innovative clinical treatment which has . . . helped individuals who
have survived trauma--including sexual abuse, domestic violence,
drive-by-shooting, combat and crime, as well as those who suffer from
depression, addiction and phobias. Through numerous case examples,
[this book] illustrates the effectiveness of Dr. Shapiro's . . . method.

Readers will see the causes for a wide variety of symptoms and how they
can be managed.
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Title: Transforming trauma: EMDR: The revolutionary new therapy for
freeing the mind, clearing the body, and opening the heart.
Author(s): Parnell, Laurel
Source: 1997. 287 pp.
Abstract: Eye movement desensitization and reprocessing (EMDR) has
helped thousands of clients haunted by terrible abuse histories or
recent traumatic events. It also benefits patients who have not found
relief with other therapies and those with such chronic conditions as
eating disorders, anxiety, low self-esteem, depression, and blocked
personal and professional performance. Drawing on her own
experiences as both EMDR client and therapist, [the author] shares . .
.stories of healing by taking readers into her clients' psyches, where
past traumas frozen in time are witnessed and then released.
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..A life transformed: Melanie's story
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Title: Treatment of Vietnam War veterans with PTSD: A comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training.
Author(s): Silver, Steven M., Veterans Affairs Medical Ctr, Posttraumatic Stress Disorder Program, Coatesville, PA, US; Brooks, Alvin; Obenchain, Jeanne
Source: Journal of Traumatic Stress, Vol 8(2), Apr 1995. pp. 337-342.
Publisher: US: Kluwer Academic/Plenum Publishers.
Abstract: Compared eye movement desensitization and reprocessing (EMDR), biofeedback (BF), and relaxation training (RT) in the treatment of Vietnam War veterans with posttraumatic stress disorder (PTSD). An inhouse program evaluation of an inpatient PTSD program was conducted during 1990-1991. 100 veterans (mean age 46 yrs) were offered EMDR, BF and group-run RT treatment in the program. Patient responses to a set of scales were collected during evaluation, at admission, and at discharge. Differences between Ss' ratings on entry and exit were used. Results show that EMDR is an effective technique in the treatment of PTSD. It produced positive incremental change in the PTSD program for nightmares, intrusive thoughts, flashbacks, anxiety, anger, depression, and relationship problems. RT produced more positive effects than BF when compared to the control group. Flaws of the study are highlighted.

Title: Use of EMDR in a "dementing" PTSD survivor.
Author(s): Hyer, Lee, Veterans Affairs Medical Ctr, Augusta, GA, US
Source: Clinical Gerontologist, Vol 16(1), 1995. pp. 70-73.
Publisher: US: Haworth Press.
Abstract: Presents a case study of a 72-yr-old woman with dementia to examine the usefulness of eye movement desensitization and reprocessing (EMDR) in treating posttraumatic stress disorder (PTSD) in "dementing" elderly. EDMR is a therapeutic tool in which clients are

made to reexperience and cognitively reprocess their trauma in imagination, moving their eyes simultaneously. It is reported to be a good instrument in treating younger survivors of trauma, however, a few studies support its use in elderly. The S experienced a series of traumatizing events. Test results showed that the S had symptoms of PTSD, depression, anxiety, and borderline dementia. After 3 sessions of EDMR, significant improvement was seen in the S, who was ready to start and lead a normal life. It is suggested that EDMR allows the client to participate in the past as currently real, and to evaluate the unfolding of the process from an observer perspective.

Title: Eye movement desensitization and reprocessing for panic disorder: A case series.
Author(s): Goldstein, Alan J., Agoraphobia & Anxiety Treatment Ctr, Bala Cynwyd, PA, US; Feske, Ulrike
Source: Journal of Anxiety Disorders, Vol 8(4), Oct-Dec 1994. pp. 351-362.
Publisher: US: Elsevier Science.
Abstract: Evaluated Eye Movement Desensitization and Reprocessing (EMDR), a technique that has shown some promise in the treatment of traumatic memories. Seven clients (aged 25-50 yrs) suffering from panic disorder received EMDR treatment for memories of past and anticipated panic attacks and other anxiety-evoking memories of personal relevance. After 5 sessions of EMDR, Ss reported a considerable decrease in the frequency of panic attacks, fear of experiencing a panic attack, general anxiety, thoughts concerning negative consequences of experiencing anxiety, fear of body sensations, depression, and other measures of pathology.

Title: PTSD in an elderly male: Treatment with eye movement desensitization and reprocessing (EMDR).
Author(s): Thomas, Robert , Dept of Veterans Affairs Medical Ctr, Family Therapy Training Program, Tucson, AZ, US; Gafner, George
Source: Clinical Gerontologist, Vol 14(2), 1993. pp. 57-59.
Publisher: US: Haworth Press.

Abstract: Administered EMDR to a 68-yr-old Native American man who suffered startle reactions, nightmares, and other posttraumatic stress disorder (PTSD) symptoms since service in World War II and the Korean War. Prior to EMDR, the S had moderate to severe depression; following 1 EMDR trial, depression was reduced to a mild level. After 2 EMDR sessions, his PTSD symptoms were ameliorated.

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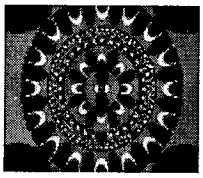
Healing With EMDR

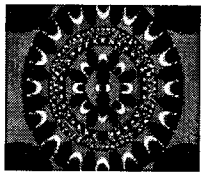
Tom Golden LCSW



A woman was walking through a park one day troubled by some pressing personal matters. When she arrived home from her walk she realized that for some unknown reason she felt much better. She knew from her training as a psychotherapist that "nothing" seemed to have happened during the time of her walk. She struggled to remember any detail that might be related to such an improvement in her mood. The only thing she could remember was that several times during the walk her eyes moved back and forth in an odd sort of way. She began experimenting with this eye movement, and after years of clinical trials by many therapists, academic research, and refining the procedures, a new psychological technique was born: EMDR.

EMDR or Eye Movement Desensitization and Reprocessing is a powerful new method of doing psychotherapy which has helped nearly a million people of all ages relieve many different types of psychological distress. It is effective in dealing with anxiety, panic, self esteem issues, disturbing memories, post traumatic stress, memories of abuse, complications of grief, and many other problems.

But we don't know exactly how it works. We do know that when a person is very upset the brain seems to be unable to process information as it does ordinarily. This difficulty in processing can continue for some time. EMDR seems to help people break this cycle by dramatically speeding up the processing of upsetting events.



The technique involves pairing the events with certain eye movements. Let's look at an example. A woman came to me some time ago because she was having trouble with upsetting and unpredictable anxiety. We worked together to identify a specific problem to be the focus of treatment. I then asked her to call to mind the disturbing material, including related thoughts, feelings, and physical sensations. As she focused on this upsetting material, she performed sets of eye movements at my direction. As she did this she simply stayed aware of what came to mind without trying to change or edit the content or direction. We continued in pairing the eye movements with the resulting thoughts and feelings as they arose. This process continued for twenty minutes to half an hour. A usual EMDR session lasts about 90 minutes when you include the time taken to prepare for the actual eye movement.

Studies have shown that treatment with EMDR consistently results in neutralizing the targeted troubling emotion or memory. The memory is still there but less painful; the sting is gone.

Additionally, the speed with which EMDR achieves this result is quicker than with traditional therapeutic techniques. For the woman in the example above five sessions of EMDR was enough for her to feel free from the original symptoms. Research indicates that the changes which result from EMDR will tend to maintain themselves over time.

One of the most positive features of this technique is that a client can't do EMDR incorrectly! Although each person processes things in his or her own unique manner, whatever comes up and gets processed is the right thing! This is a dramatic difference from the old methods of therapy which relied more heavily on the insight of the client and the direction given by the therapist. EMDR, which is one of the first female-created forms of psychotherapy, fosters a new and interdependent type of alliance between client and therapist.

EMDR is not a panacea but it is a powerful technique which can quickly and easily help us enjoy our lives in greater peace.

Tom Golden is a professional speaker, author, and psychotherapist whose area of specialization is healing from loss and trauma. Tom gives workshops across the country and in Canada on many aspects of this topic. His **workshops** are known to be both entertaining and informative. Contact Tom at the addresses below (email or snail mail) for inquiries about speaking or training for your group. You can also order his book **Swallowed by a Snake: The Gift of the Masculine Side of Healing on this site or** through **Amazon.com**

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This site is dedicated to my father Thomas S. Golden, who died in Nov. of 1994.

EMDR and MEDITATION
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EMDR and Meditation

This site is designed to explore the benefits of combining EMDR with meditation. Over the past several years, I have been increasingly drawn to the practice of meditation and have been amazed at the depth of insight and awareness it has fostered. As a clinical psychologist, I have found Eye Movement Desensitization and Reprocessing (EMDR) to be an incredibly powerful and helpful form of psychotherapy. Yet, I have realized that often neither mindful practices nor therapy alone is enough. Instead, I thought how useful it would be to combine the evocative power of meditation with the possibilities for change and healing offered by EMDR. This site is designed to further that exploration. I invite any comments, questions or suggestions you may have.

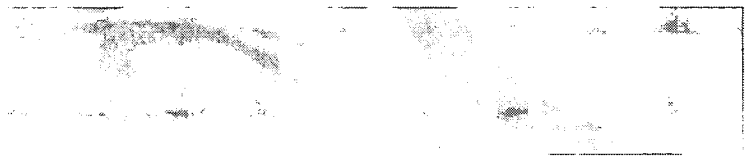
William M. Zangwill, Ph.D.

Health Psychology Home Page

Papers written by students providing scientific reviews of topics related to health and well being

Treating Post-Traumatic Stress Disorder (PTSD) with EMDR

Christoph Rothmayr



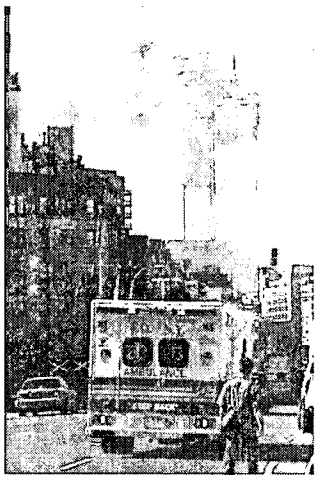
It's probably one of the most controversial and fascinating discoveries psychologists have come up with in the past few years: EMDR. The abbreviation stands for " Eye Movement Desensitization and Reprocessing ".
During EMDR treatment the therapist waves his fingers in front of the patient's eyes, the patient follows the therapist's finger as they move slowly from the left to the right. For

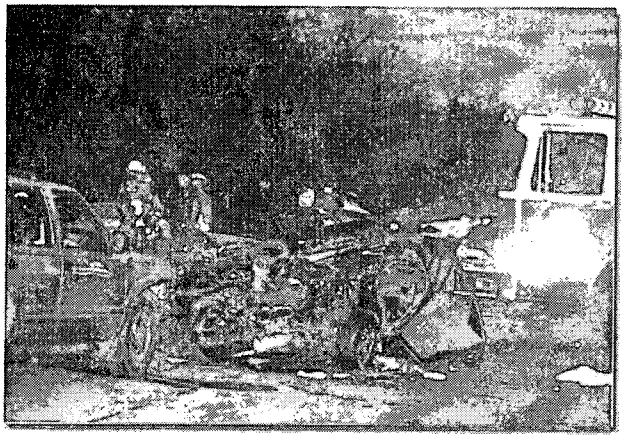
many therapists EMDR is the treatment of choice when it comes to clients with Post-Traumatic Stress Disorder (PTSD).

The following paragraphs will try to focus on where EMDR comes from, what it exactly is, how it works and what scientists think about it. All of this will be considered with a special emphasis on PTSD.
First of all we want to discuss what PTSD actually is.

What is PTSD?

Post-Traumatic Stress Disorder is a severe psychiatric disorder that may occur after a traumatic experience that involves actual or threatened death or serious injury, or other threats to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person (according to the Diagnostical and Statistical Manual of Mental Disorders (DSM IV-TR) by the American Psychiatric Association).
Such threatening experiences may be rape, physical attack, natural disasters, automobile accidents, military combat, or terrorist attacks.





People with PTSD often relive such experiences through nightmares and flashbacks (components of the threatening event are relived as though experiencing the event at the moment), sleeping problems, fear, helplessness and horror. People with PTSD have a higher probability to suffer from depression, anxiety or phobias.
About 8% of Americans will experience PTSD at some point in their lives. Women are twice as likely as men to develop PTSD. Next to EMDR PTSD is also treated with cognitive-behavioral therapy and/or drugs such as Zoloft® or Prozac®. (For more information on PTSD go to www.ncptsd.org)

The History of EMDR

As mentioned before, EMDR is a rather new way of treating mental disorders such as PTSD.
EMDR was discovered in 1987 by Francine Shapiro, Ph.D.
Dr. Shapiro was suffering from negative distressing memories that caused her negative emotions. While walking in a park one day she realized that moving her eyes while thinking about he threatening experiences helped her decrease the negative symptoms associated with the stressful event.
She then further investigated her discovery and did some research on how this finding, which she first called EMD (Eye Movement Desensitization) might be applied to disorders like PTSD.
After several studies in which she investigated the effect of EMDR on PTSD she changed the name EMD to EMDR (Eye Movement Desensitization and Reprocessing) in 1991.
(A detailed biography of Dr. Shapiro can be found at: www.emdr.com)

The Eight Stages of EMDR Treatment

Treating patients suffering from PTSD with EMDR includes more than just moving fingers in front of somebody's eyes. EMDR actually also integrates elements from other psychotherapies such as cognitive-behavioral, interpersonal, experiential and body-centered therapies.

In the first phase the assessment of the client's stressful experiences takes place. The symptoms and thoughts the patient wants to get rid off are discussed and goals of the treatment are set.

In the second phase the therapist makes sure that the patient is in a relatively stable phase before talking about the threatening experiences. The client may want to learn special relaxation techniques if he or she does not seem stable enough to once again go through the threatening events mentally.

In phases three to six images, beliefs, emotions and body sensations that are related to the threatening event are identified and discussed. After identifying these items the client focuses on them while following the therapist's finger that is moving back and forth. This is repeated until the patient does not feel distressed anymore while thinking of the formerly bad memories. The client is then instructed to think of a positive belief that the therapist and the patient have agreed on before.

Afterwards in phase seven the client is asked to write down anything that is referred to the stressful event and may occur in the time after the last treatment session.

In phase eight, which is usually conducted in the next treatment session, changes to the client's situation are evaluated.
(For further information go to www.emdr.com)

The Theory behind EMDR

One of the most popular theories of how EMDR works comes from Francine Shapiro who has, as mentioned before, developed EMDR therapy. Her theory of explaining EMDR is called the "Adaptive Information Processing Model".
The basic assumption of the model is that all humans possess an information processing system that processes experiences and stores these as memories in a way that they are easily accessible and linked to a network of accompanying images, sensations, emotions

and beliefs.

When it comes to a threatening and traumatic event such as those causing PTSD, that processing system may sometimes not work sufficiently. As a result of this the event is linked only with negative images, beliefs and sensations. A connection with more adaptive (=alternative explanatory) information does not take place. This may be due to the strong negative feelings involved. Therefore whenever the person thinks of the traumatic event again only bad memories will come up again since the event has not yet been processed and stored in an entire and appropriate way.

EMDR can then help to further process stressful events by a learning process that first links the negative memories to the eye-movements. The negative memories are then connected to more adaptive and positive beliefs that the client and the therapist have discussed previously.

What does Science Think about EMDR? – A Literature Review

EMDR is probably one of the most spectacular and most popular therapies in recent years for the treatment of mental disorders, especially for PTSD. EMDR has also been controversly discussed in the scientific world like no other treatment since it was first presented more than 10 years ago.

Is EMDR effective?

The most important questions that the treatment had and still has to face are definitely: is it more (or even less) effective than *no* treatment? and also: is it more (or less) effective than *other* common treatments? A lot of research has been conducted to answer this question that may be crucial for the survival of EMDR as a treatment for disorders like PTSD.

One of the research articles clearly in favor of the effectiveness of EMDR for the treatment of PTSD is a study by M.M.Scheck, J.A.Schaeffer and C.Gilette in the Journal of Traumatic Stress (1998). In this study 60 traumatized women were treated with either EMDR or an active listening (AL) control treatment. The AL control consisted of listening to the patient and non-evaluative acknowledgement of the patient's reports. With the AL control condition the authors tried to control so called "placebo" factors such as rapport, sympathetic attention and expectation of gain. For the outcome-measures the Beck Depression Inventory, the State-Trait Anxiety Inventory, the Penn Inventory

for PTSD, the Impact of Event Scale and the Tennessee Self-Concept Scale were used. Factorial ANOVA revealed that in both treatments an improvement of the patients' state had taken place. However in the EMDR group this effect was significantly larger than in the AL group. This finding therefore stands for the superiority of EMDR against an AL treatment in PTSD treatment.

However, this study tells us nothing about the effectiveness of EMDR in PTSD compared to more commonly used PTSD treatments other than AL (not a broadly used PTSD treatment). One of the most recent evaluations on the effectiveness of EMDR was a meta-analysis conducted by Paul R. Davidson and Kevin C.H. Parker from the Queen's University in Kingston, Ontario, Canada (Davidson & Parker, 2001). A meta-analysis takes a look at a number of scientific research articles that all have one thing in common: The investigation of certain topic. These articles are then all put together. An overall test of statistical significance is then conducted in order to get an insight to a question all of those articles have dealt with.

In the Davidson & Parker meta-analysis EMDR treatment was compared to no treatment, treatment with not using exposure to anxiety-provoking stimuli and exposure therapy (a commonly used technique in PTSD treatment).
34 studies from 1988 to April 2000 were included in this meta-analysis. Effect sizes were then estimated for each study using Rosenthal's formula. Effect sizes range from −1 to +1, a positive number indicates a positive effect of a treatment. After that was done an ANOVA with the obtained data was conducted.

The statistical evaluation showed an overall effect of EMDR when comparing pre- and post- treatment values ($p \leq .01$). According to the statistical analysis EMDR is also more effective than a no-treatment or a waiting list condition ($p \leq .01$) and more effective than non-specific (no-exposure) treatment ($p \leq .05$). However, there was no significant difference in the effectiveness of EMDR compared to exposure-therapy (in vivo or not in vivo) or to cognitive-behavioral therapy (CBT).

The question if EMDR is better than other widely used treatments for PTSD, such as exposure-based treatments, must therefore be answered with no. At least in the Davidson & Parker meta-analysis there was no evidence that EMDR is to be preferred over exposure-based treatments. Nonetheless EMDR has shown to be more effective than non exposure-based treatments or no treatment at all.

How essential are the eye-movements?

In a sub-analysis included in the Davidson & Parker meta-analysis 13 studies were

examined that compared EMDR treatments with an eye-movement condition to an EMDR treatment with an eyes-fixed condition. After calculating effect-sizes and comparing those in a statistical analysis using multiple t-tests no benefit of EMDR treatments with eye-movements could be shown. Therefore there is no evidence that eye-movements, that once gave EMDR its name and probably are part of its fame, are a necessary component of EMDR therapy.

Conclusion

EMDR has so far failed to prove that is more effective than other standard treatments used for the treatment of PTSD. Also eye-movements that were supposed to be an essential part of EMDR seem to be of no significance. Since EMDR is such a new treatment it still suffers from a substantial variance in findings from study to study, which may account for its lack of superiority to other standard treatments. Even if EMDR may not be as successful as many therapists still believe it has definitely shown us one thing: that we must not only rely on old-fashioned therapies but that we should always keep our eyes and ears open for innovative treatments in the future.

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American Psychiatric Association. (1997). *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)*. Washington, DC: Author

Davidson, P. R. & Parker, K. C. H. (2001). Eye Movement Desensitization and Reprocessing (EMDR): A Meta-Analysis. *Journal of Counseling and Clinical Psychology, 69 (2)*, 305-316

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Scheck, M. M., Schaeffer, J. A., Gilette, C. (1998). Brief Psychological Intervention with Traumatized Young Women: The Efficacy of Eye Movement Desensitization and Reprocessing. *Journal of Traumatic Stress, 11 (1),* 35-42

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PTO Form 1957 (Rev 9/2005)
OMB No. 0651-0050 (Exp. 04/2009)

Response to Office Action

The table below presents the data as entered.

Input Field	Entered
SERIAL NUMBER	78951781
LAW OFFICE ASSIGNED	LAW OFFICE 108
MARK SECTION (no change)	
GOODS AND/OR SERVICES SECTION (current)	
INTERNATIONAL CLASS	035
DESCRIPTION	
Association services, namely, for an organization of clinical and research psychologists	
FILING BASIS	Section 1(a)
FIRST USE ANYWHERE DATE	At least as early as 03/23/2006
FIRST USE IN COMMERCE DATE	At least as early as 03/23/2006
GOODS AND/OR SERVICES SECTION (proposed)	
INTERNATIONAL CLASS	035
DESCRIPTION	
Association services, namely, promoting the interests of clinical and research psychologists, in International Class 35	
FILING BASIS	Section 1(a)
FIRST USE ANYWHERE DATE	At least as early as 03/23/2006
FIRST USE IN COMMERCE DATE	At least as early as 03/23/2006
ADDITIONAL STATEMENTS SECTION	
DISCLAIMER	"No claim is made to the exclusive right to use EMDR International Association apart from the mark as shown."
	"The color(s) The Applicant claims that certain colors are a feature of its mark. The colors dark blue and light blue are claimed as a feature of the mark. The color dark blue appears in

COLOR(S) CLAIMED (If applicable)	the wording "EMDR International Association" and in the letters "EMDR" in the word "EMDRIA." The color light blue appears in the design elements in the letters "IA" in the word "EMDRIA." The color white, which surrounds the mark, represents transparent matter and is not part of the mark. is/are claimed as a feature of the mark."
	Section 2(d) Likelihood of Confusion: Review of factors from In Re: E. I. Du Pont de Nemours & Co., 177 U.S.P.Q. 563, 476 F.2d 1357 (Court of Customs and Patent Appeals 1973) regarding likelihood of confusion (1) The similarity or dissimilarity of the marks in their entireties as to appearance, sound, connotation and commercial impression: The registered marks in question are different from the Applicant's proposed mark. Registration No. 1808113 is for the design mark containing the letters "EMDR" within a circle, which is itself within an oval. As a whole, the logo is a symbolic representation of an eye. Such mark actually recalls the old Columbia Broadcasting System "eye" television logo. Registration No. 1986652 is for the typed word mark "EMDR." Such mark has been cancelled as of April 17, 2007 and should not be considered as a bar to the present application. Since it has been cancelled, the Applicant will not refer further to such registration number in this response. Registration No. 2117226 is actually the name of the trademark holder, "EMDR Institute, Inc." The Applicant's proposed mark, EMDRIA/EMDR International Association and design, is different from the registered marks, in that it contains the acronym of the Applicant's name, "EMDRIA," and also has the Applicant's name in written form, EMDR International Association. The mark also contains design elements of arrows pointing in different directions, as a symbolization of the psychological process encompassed by eye movement desensitization and reprocessing. As pointed out by Robert J. Lavache, the Examining Attorney, all of the marks in question all have the acronym "EMDR" as at least one of their distinctive features. The Examining Attorney has also pointed out that the "EMDR" element of the mark "merely describes a purpose, function, feature, and/or characteristic of the applicant's services," suggesting that the EMDR element itself could not function as a service mark as it is merely descriptive. If such element is deemed as merely descriptive, the presence of such element should not be considered as creating a likelihood of confusion with other marks. (2) The similarity or dissimilarity and nature of the goods or services as described in an application or registration or in connection with which a prior mark is in use. The goods and services identified by EMDR Institute, Inc., the owner of the registered marks in Registration No. 1808113 are "educational seminars for professionals in the field of mental health" in Class 41. The goods and services identified by EMDR Institute, Inc. in Registration No. 2117226 are "educational services, namely seminars, workshops, classes and training, in the field of psychology and psychotherapy" in Class

MISCELLANEOUS STATEMENT	41, and "psychological testing and consultation services and psychotherapy services," in Class 42. The services identified are both the actual professional services in the field of eye movement desensitization and reprocessing, and educational services for professionals involved in such field. The Applicant's services, on the other hand, are focused on trade association services, for professionals involved in the field of eye movement desensitization and reprocessing. The Applicant's purpose is (a) to establish and uphold standards of practice, training, certification, and research in the field of EMDR, (b) to provide information, education, and advocacy regarding EMDR, and (c) to assist practitioners of EMDR in fulfilling their responsibilities to the public. Certainly, part of the Applicant's association services include educational services to some extent, but as stated above, the Applicant's purpose goes far beyond educational services. (3) The similarity or dissimilarity of established, likely-to-continue trade channels. EMDR Institute, Inc., the owner of the registered marks, and EMDR International Association, the Applicant, each have an established presence on their respective Internet web pages. The web pages among the two organizations differ greatly. The EMDR Institute, Inc.'s site, at www.emdr.com, appears to have some basic educational information about eye movement desensitization and reprocessing, and is apparently targeted directly to medical professionals involved in this field. The Applicant's website, at www.emdria.org, is also targeted to medical professionals, but it contains information about the Applicant's services as a trade association for professionals involved in the field of EMDR. (4) The conditions under which, and buyers to whom, sales are made, i.e. "impulse" vs. careful, sophisticated purchasing. Both entities deal with mental health professionals that practice that certain field of therapy known as EMDR. This is a relatively limited market. The services available through each entity are the result of careful, sophisticated purchasing by professionals. The Applicant is a membership organization, and membership is a requirement in order to gain access to some of its services. Membership in an association would make it more unlikely to be confused by another entity's trademarks. (5) The fame of the prior mark (sales, advertising, length of use). EMDR Institute, Inc. has been using its EMDR design logo since June of 1989 and the word mark since June of 1993. The Applicant has been using its present design of mark since 2006. Prior to that, the Applicant used a previous version of a logo (Registration No. 2141815) since November of 1995. As seen on its website, at www.emdria.org, the Applicant is using its new logo on virtually every page of its website. (6) The number and nature of similar marks in use on similar goods. Applicant is not aware of any similar marks used in connection with the field of eye movement desensitization and reprocessing. (7) The nature and extent of any actual confusion. Applicant is not aware of any actual confusion between its mark and the registered marks of

EMDR Institute, Inc. The professionals involved in this field, being the Applicant's target market, are aware of the existence of the two entities, being the Applicant and EMDR Institute, Inc. (8) The length of time during, and conditions under which, there has been concurrent use without evidence of actual confusion. There has been concurrent use of a previous design of Applicant's logo (Registration No. 2141815) and the EMDR Institute, Inc.'s marks, since November of 1995, without evidence of actual confusion between the respective marks. The Applicant has used its new design logo since June of 2006, again without evidence of actual confusion. (9) The variety of goods on which a mark is or is not used (house mark, "family" mark, product mark). Both entities, the EMDR Institute, Inc. and EMDR International Association, use their respective marks on each page of their respective internet websites. Both entities also use their respective marks on printed material made available through the entities. These printed materials are utilized by psychological professionals and clinicians. (10) The market interface between applicant and the owner of a prior mark: (a) a mere "consent" to register or use; (b) agreement provisions designed to preclude confusion, i.e. limitations on continued use of the marks by each party; (c) assignment of mark, application, registration and good will of the related business; (d) laches and estoppel attributable to owner of prior mark and indicative of lack of confusion. The Applicant submits herewith a consent agreement it has with EMDR Institute, Inc. There is a high degree of interaction between the EMDR Institute, Inc. and EMDR International Association. A part of this interaction is signified by the fact that the EMDR Institute, Inc. website has a link to the Applicant's website, at http://www.emdr.com/organizations.htm. (11) The extent to which applicant has a right to exclude others from use of its mark on its goods. The Applicant has used its own logo since November of 1995, and has always had the right to exclude others from using the Applicant's mark. Indeed, a large part of Applicant's mark is its corporate name, being "EMDR International Association." The Texas Secretary of State has the right to deny incorporation to any proposed corporation using a name so similar to that of the Applicant as to be likely to cause confusion. (12) The extent of potential confusion, i.e., whether de minimis or substantial. As stated above, because the target market for the Applicant and for the EMDR Institute, Inc. consists of medical professionals, the audience of the marks in question are sophisticated consumers of the services of the Applicant and of the EMDR Institute, Inc. Therefore, the potential for confusion among the various marks is de minimis. (13) Any other established fact probative of the effect of use. As stated above, the Applicant and the EMDR Institute, Inc. both deal with a similar target market, being mental health professionals. The services the two entities provide are different, in that the EMDR Institute, Inc. appears to be focused primarily on education of professionals, while the Applicant

	provides a wide range of services to promote the interests of the mental health community involved in this type of therapy. Ownership of prior registration: The Applicant is the owner of U. S. Registration No. 2145815. The mark included in this application represents a revision of the logo in such prior registration. License and Consent Agreement: The Applicant attaches hereto a copy of a License and Consent Agreement between the Applicant and EMDR Institute, Inc., the owner of marks referred to in Registration Nos. 1808113 and 2117226. Registration No. 1986652 is not covered by this Agreement, as such registration has been canceled.
MISCELLANEOUS FILE NAME(S)	
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CONVERTED PDF FILE(S) (7 pages)	\\TICRS2\EXPORT13\789\517\78951781\xml1\ROA0002.JPG
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SIGNATURE SECTION	
RESPONSE SIGNATURE	/Thomas P. Washburn/
SIGNATORY'S NAME	Thomas P. Washburn
SIGNATORY'S POSITION	Attorney of record
DATE SIGNED	07/18/2007
AUTHORIZED SIGNATORY	YES
FILING INFORMATION SECTION	
SUBMIT DATE	Wed Jul 18 16:45:41 EDT 2007
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PTO Form 1957 (Rev 9/2005)
OMB No. 0651-0050 (Exp. 04/2009)

Response to Office Action

To the Commissioner for Trademarks:

Application serial no. **78951781** has been amended as follows:

CLASSIFICATION AND LISTING OF GOODS/SERVICES
Applicant proposes to amend the following class of goods/services in the application:
Current: Class 035 for Association services, namely, for an organization of clinical and research psychologists
Original Filing Basis:
Filing Basis: Section 1(a), Use in Commerce: The applicant is using the mark in commerce, or the applicant's related company or licensee is using the mark in commerce, on or in connection with the identified goods and/or services. 15 U.S.C. Section 1051(a), as amended. The mark was first used at least as early as 03/23/2006 and first used in commerce at least as early as 03/23/2006, and is now in use in such commerce.

Proposed: Class 035 for Association services, namely, promoting the interests of clinical and research psychologists, in International Class 35
Filing Basis: Section 1(a), Use in Commerce: The applicant is using the mark in commerce, or the applicant's related company or licensee is using the mark in commerce, on or in connection with the identified goods and/or services. 15 U.S.C. Section 1051(a), as amended. The mark was first used at least as early as 03/23/2006 and first used in commerce at least as early as 03/23/2006, and is now in use in such commerce.
ADDITIONAL STATEMENTS
Disclaimer
"No claim is made to the exclusive right to use EMDR International Association apart from the mark as shown."

Color Claim
"The color(s) The Applicant claims that certain colors are a feature of its mark. The colors dark blue and light blue are claimed as a feature of the mark. The color dark blue appears in the wording "EMDR International Association" and in the letters "EMDR" in the word "EMDRIA." The color light blue appears in the design elements in the letters "IA" in the word "EMDRIA." The color white, which surrounds the mark, represents transparent matter and is not part of the mark. is/are claimed as a feature of the mark."

Section 2(d) Likelihood of Confusion: Review of factors from In Re: E. I. Du Pont de Nemours & Co., 177 U.S.P.Q. 563, 476 F.2d 1357 (Court of Customs and Patent Appeals 1973) regarding likelihood of confusion (1) The similarity or dissimilarity of the marks in their entireties as to appearance, sound, connotation and commercial impression: The registered marks in question are different from the Applicant's proposed mark. Registration No. 1808113 is for the design mark containing the letters "EMDR" within a circle, which is itself within an oval. As a whole, the logo is a symbolic representation of an eye. Such mark actually recalls the old Columbia Broadcasting System "eye" television logo. Registration No. 1986652 is for the typed word mark "EMDR." Such mark has been cancelled as of April 17, 2007 and should not be considered as a bar to the present application. Since it has been cancelled, the Applicant will not refer further to such registration number in this response. Registration No. 2117226 is actually the name of the trademark holder, "EMDR Institute, Inc." The Applicant's proposed mark, EMDRIA/EMDR International Association and design, is different from the registered marks, in that it contains the acronym of the Applicant's name, "EMDRIA," and also has the Applicant's name in written form, EMDR International Association. The mark also contains design elements of arrows pointing in different directions, as a symbolization of the psychological process encompassed by eye movement desensitization and reprocessing. As pointed out by Robert J. Lavache, the Examining Attorney, all of the marks in question all have the acronym "EMDR" as at least one of their distinctive features. The Examining Attorney has also pointed out that the "EMDR" element of the mark "merely describes a purpose, function, feature, and/or characteristic of the applicant's services," suggesting that the EMDR element itself could not function as a service mark as it is merely descriptive. If such element

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(9) The variety of goods on which a mark is or is not used (house mark, "family" mark, product mark). Both entities, the EMDR Institute, Inc. and EMDR International Association, use their respective marks on each page of their respective internet websites. Both entities also use their respective marks on printed material made available through the entities. These printed materials are utilized by psychological professionals and clinicians. (10) The market interface between applicant and the owner of a prior mark: (a) a mere "consent" to register or use; (b) agreement provisions designed to preclude confusion, i.e. limitations on continued use of the marks by each party; (c) assignment of mark, application, registration and good will of the related business; (d) laches and estoppel attributable to owner of prior mark and indicative of lack of confusion. The Applicant submits herewith a consent agreement it has with EMDR Institute, Inc. There is a high degree of interaction between the EMDR Institute, Inc. and EMDR International Association. A part of this interaction is signified by the fact that the

EMDR Institute, Inc. website has a link to the Applicant's website, at http://www.emdr.com/organizations.htm. (11) The extent to which applicant has a right to exclude others from use of its mark on its goods. The Applicant has used its own logo since November of 1995, and has always had the right to exclude others from using the Applicant's mark. Indeed, a large part of Applicant's mark is its corporate name, being "EMDR International Association." The Texas Secretary of State has the right to deny incorporation to any proposed corporation using a name so similar to that of the Applicant as to be likely to cause confusion. (12) The extent of potential confusion, i.e., whether de minimis or substantial. As stated above, because the target market for the Applicant and for the EMDR Institute, Inc. consists of medical professionals, the audience of the marks in question are sophisticated consumers of the services of the Applicant and of the EMDR Institute, Inc. Therefore, the potential for confusion among the various marks is de minimis. (13) Any other established fact probative of the effect of use. As stated above, the Applicant and the EMDR Institute, Inc. both deal with a similar target market, being mental health professionals. The services the two entities provide are different, in that the EMDR Institute, Inc. appears to be focused primarily on education of professionals, while the Applicant provides a wide range of services to promote the interests of the mental health community involved in this type of therapy. Ownership of prior registration: The Applicant is the owner of U. S. Registration No. 2145815. The mark included in this application represents a revision of the logo in such prior registration. License and Consent Agreement: The Applicant attaches hereto a copy of a License and Consent Agreement between the Applicant and EMDR Institute, Inc., the owner of marks referred to in Registration Nos. 1808113 and 2117226. Registration No. 1986652 is not covered by this Agreement, as such registration has been canceled.

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The signatory has confirmed that he/she is an attorney who is a member in good standing of the bar of the highest court of a U.S. state, which includes the District of Columbia, Puerto Rico, and other federal territories and possessions; and he/she is currently the applicant's attorney or an associate thereof; and to the best of his/her knowledge, if prior to his/her appointment another U.S. attorney or a Canadian attorney/agent not currently associated with his/her company/firm previously represented the applicant in this matter: (1) the applicant has filed or is concurrently filing a signed revocation of or substitute power of attorney with the USPTO; (2) the USPTO has granted the request of the prior representative to withdraw; (3) the applicant has filed a power of attorney appointing him/her in this matter; or (4) the applicant's appointed U.S. attorney or Canadian attorney/agent has filed a power of attorney appointing him/her as an associate attorney in this matter.

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EMDR Training Program

EMDRIA-Approved "EMDR Basic Training" -- the complete course. For therapists working with *all ages - adults and kids.*

49 CE's - 4 graduate credits (optional)

This is a ***hands-on clinical skills training*** for using EMDR and integrating it with your psychotherapy approach. This top-of-the-line training program features:

- Exceeds EMDRIA's criteria for EMDR basic training.
- No "Parts" or "Levels" -- this is the whole package.
- 52 contact hours over several months to support mastery.
- Two full pre-EMDR days on trauma treatment approach and interventions.
- Small group size (max of 30, most courses smaller).
- Instructor to participant ratio of at least 1:10.
- Text book and other materials included.
- Follow-up group consultation sessions included.
- Competitive cost.
- On-site training option minimizes travel costs for your group.

The training program involves lecture, demonstration, in-class practice, and on-the-job practice with your clients. This is an experiential training, and part of the learning is to practice the interventions with other participants.

Training can be provided at your location. Scheduling is flexible and can be designed to suit the needs of your organization or group.

Objectives:
Participants will be able to:

- Identify clients who are ready for EMDR; and prepare clients for EMDR.
- Conduct an EMDR session.
- Problem-solve a session that is not going smoothly.
- Utilize EMDR with a wide range of clients whose presenting problems are in some way related to trauma and/or loss.
- Integrate EMDR into a comprehensive trauma-informed treatment approach.

Instructors: Ricky Greenwald, PsyD | Andrew Seubert, LPC | Mary L. Froning, PsyD | Leslie Adler, PhD |

Annie Monaco, LCSW-R

Text books:
Greenwald, R. (2007). EMDR Within A Phase Model Of Trauma-Informed Treatment. NY: Haworth. (included with course materials)
Shapiro, F. (2001). Eye Movement Desensitization and Reprocessing: Basic principles, protocols, and procedures, 2nd Edition. NY: Guilford.

Who may attend: EMDR training is open to mental health professionals who are licensed (or certified or registered) by their state for independent practice. The training is also open to advanced graduate students, interns, and other mental health professionals on a licensure track, with a letter of support from their supervisor. The Trauma Institute/Child Trauma Institute or the Registrar of your local training can answer your questions regarding eligibility for training.

Upcoming Trainings:

- Winter/Spring, 2011, **Washington, DC area.** Dates: February 26-27, 2011; March 19 (2 hrs only); April 2-3; April 9-10; May 7 (half day); June 4 (half day). Co-sponsored by R. Cassidy Seminars. Instructor: Mary L. Froning, Psy.D. Send e-mail or call 202-244-9194 for schedule and registration info.

- Spring, 2011, **Elmira, NY.** Dates: March 17-18, 2011; April 25-28; additional dates (1.5 days) TBA. Co-sponsored by R. Cassidy Seminars. Instructor: Andrew Seubert, LPC. Send e-mail or call (570) 662-2805 for schedule and registration info.

- Spring, 2011, **Greenfield, MA.** Dates: Mon-Tue March 28-29, 2011; Mon-Thur May 2-5; Mon June 6; and Mon (morning only) June 27. Co-sponsored by R. Cassidy Seminars. Instructor: Ricky Greenwald, Psy.D.

  - Earlybird: $1,400; After February 14: $1,500; After March 15: $1,550. Register (no CEs)
  - Earlybird: $1,400; After February 14: $1,500; After March 15: $1,550. 49 CEs adds $40 Register (+ CEs)

- Spring/Summer, 2011, **Mechanicsburg/Harrisburg, PA.** Dates: May 3-4; June 21-24; additional dates (1.5 days) TBA. Co-sponsored by R. Cassidy Seminars. Instructor: Andrew Seubert, LPC. Send e-mail or call (570) 662-2805 for schedule and registration info.

- Fall, 2010, **State College, PA.** Dates: September 8-9, 2011; October 17-20; additional dates (1.5 days) TBA. Co-sponsored by R. Cassidy Seminars. Instructor: Andrew Seubert, LPC. Send e-mail or call (570) 662-2805 for schedule and registration info.

- Fall, 2011, **Washington, DC area.** Dates: September 10-11, 2011; October 1 (2 hrs only); October 22-23; October 29-30; November 19 (half day); December 17 (half day). Co-sponsored by R. Cassidy Seminars. Instructor: Mary L. Froning, Psy.D. Send e-mail or call 202-244-9194 for schedule and registration info.

- Fall, 2011, **Minneapolis, MN.** Dates: TBA. Co-sponsored by R. Cassidy Seminars. Instructors: Leslie Adler, PhD and Annie Monaco, LCSW-R.

  - Earlybird: $1,400; After August 1: $1,500; After September 1: $1,550. Register (no CEs)
  - Earlybird: $1,400; After August 1: $1,500; After September 1: $1,550. 49 CEs adds $40 Register (+ CEs)

- Otherwise, only closed trainings are scheduled (e.g. for an agency or institution). To schedule a training for

your group, contact the Trauma Institute/Child Trauma Institute. Individuals may also organize trainings and receive a discount on tuition.

A note about the cost of training: At about $1,500/participant, this training represents a considerable investment. The cost is so high because of the instructor:participant ratio and the number of hours. At some locations a bit is added to cover instructor travel. Even so, the cost is considerably less than comparable programs, while offering more materials, small group size, and the 10 consultation hours that are required for completion of EMDR training. Also, the Trauma Institute/Child Trauma Institute trainings can be offered at your location, reducing or eliminating your travel-related costs.

Most importantly, though, this training is designed to maximize your ability to get good at doing EMDR, and at conducting treatment so that EMDR can be used appropriately. EMDR is a complex intervention that takes a lot of training and supervised practice to really master. We pioneered the full-package EMDR training, which has become the standard nationwide. We believe that our program represents an excellent value for your training investment.

Certification in EMDR: The EMDR International Association (EMDRIA) also offers a Certification credential for advanced EMDR-trained therapists. Certification requires completion of an EMDRIA-approved basic training program (such as this one), practice with clients, EMDR-focused consultation, and continuing education approved by EMDRIA. Information about Certification can be found on the EMDRIA web site.

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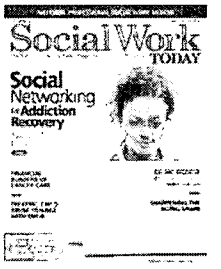

Treating Child Abuse Trauma With EMDR

By Deborah R. Huso

Social Work Today
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EMDR has been successful in treating trauma from childhood abuse in victims and survivors young and old.

With more than 3 million instances of child abuse reported annually in the United States and probably many more cases going unreported, social workers face an often daunting client list of children and adults who are or have been victims of abuse and neglect. Left untreated, these individuals' chances of leading lives fraught with substance abuse, incarceration, unwanted pregnancies, and future psychological conditions are multiplied by many degrees.

In the last two decades, however, researchers have made major strides in developing methods for treating victims and survivors of child abuse, including therapies that work as well (and in some cases better) with children as with adults. Among the most successful of these treatments is Eye Movement Desensitization and Reprocessing (EMDR), a therapeutic process that uses eye movements, sounds, and repetitive motions to help clients process and come to terms with traumatic memories more quickly than talk therapy alone. And since many children and some adults are unable to verbalize traumatic experiences, EMDR can often provide the breakthrough that more traditional therapies can't.

How EMDR Works

EMDR is a therapeutic treatment that uses eye movements, sounds, or pulsations to stimulate the brain. Using these sensory experiences in conjunction with focusing on a traumatic memory can create changes in the brain that help a client overcome symptoms of depression, anger, and anxiety, among other conditions. Francine Shapiro, PhD, executive director of the EMDR Institute, developed the process 20 years ago. While researchers cannot say with certainty why EMDR works in helping patients resolve trauma, it is now the most researched psychotherapeutic treatment for posttraumatic stress disorder (PTSD).

Unlike prolonged exposure therapy (PET), EMDR does not necessarily require the client to relate his or her trauma aloud or cover it in any particular sequence. The therapist just follows the client along his or her journey through memory while periodically asking what he or she is noticing. When each new stage of the memory is reached, the therapist "installs" the memory with eye movements or tapping. Essentially, an EMDR session allows a client to mentally visit a disturbing memory in brief doses while simultaneously focusing on an external stimulus. Not only does EMDR help clients create new associations with traumatic memories, it also helps reduce sensitivity to external events that can trigger those memories while allowing them to learn to exercise control over the future.

Using EMDR With Children

Ricky Greenwald, PsyD, affiliate professor at the SUNY University at Buffalo School of Social Work and executive director of the Trauma Institute & Child Trauma Institute, has written extensively on EMDR over the course of the last two decades. Author of ***EMDR Within a Phase Model of Trauma-Informed Treatment***, he is one of the earliest experts in the field and has employed EMDR in his counseling of more than 1,000 people.

While he admits that it's more common for therapists to use PET when working with child trauma, he's a strong advocate of using EMDR with children. While most EMDR research has been conducted on adults, he believes the treatment works especially well with children, as they tend to take to the process more quickly than adults. And he points out that it has consistently outperformed cognitive-behavioral therapy (CBT) in providing quicker resolution to trauma victims.

Natalie Robinson, LICSW, a consultant and trainer who has been using EMDR in her practice for 15 years, is a strong proponent of using the technique with children. Child abuse survivors are a major part of her caseload and she has found that where children are concerned, talk therapy has often not been enough to heal them. Robinson says EMDR is actually trickier with adults, especially in instances of sexual abuse, as these adults have trouble trusting anyone, so it takes time to create an alliance with the therapist before they can even consider proceeding with EMDR.

Why It Works

Greenwald believes the main reason EMDR is so effective is because it happens inside the client's mind. "People think, on average, seven times faster than they talk," he points out, and since EMDR doesn't require the client to talk through everything he or she is mentally experiencing, it enables individuals to deal with traumatic memories more quickly.

Greenwald says since the trauma survivor is concentrating on the memory along with something external, it creates a dual focus that allows the individual to be both in the memory and an observer of it at the same time.

"It combines psychoanalysis, body sensations, and psychotherapy all at once," Robinson adds. "It has a bit of hypnotherapy, too, so it really offers the best from many worlds of therapy."

Robinson says talking alone reaches only the left side of a victim's brain while EMDR stimulates both hemispheres. "EMDR allows us to build synapses in the brain around traumatic experiences," she explains. "It allows the victim to combine his or her experience with wisdom." Robinson says one way of understanding EMDR is to think of it like REM sleep. It helps people process their memories and put them in the past instead of the present.

Joanne Twombly, LICSW, who works in private practice in Waltham, MA, has been using EMDR for treating severe dissociative disorders for about 10 years. She works with clients with what she calls "huge child abuse issues" and complex PTSD. "What I find is that bilateral stimulation, mostly bilateral tapping, helps to install coping skills," she says. Twombly points out that brain scans show the frontal lobes of the brain in trauma victims are often impaired. She says EMDR activates those frontal lobes in a way talk therapy can't. "Trauma gets stuck in the primitive part of the brain," Twombly adds. "EMDR gets into the part of the brain where those stuck things reside."

Sara Biel, LCSW, doesn't necessarily use bilateral eye movements in EMDR and says tapping on hands or knees will work just as well. "It's about stimulating both sides of the brain," she explains. "It's similar to the eye movements we have during sleep. Like sleep, EMDR helps us process memory and move experiences into the past."

Greenwald disagrees with the idea that EMDR calls on both the right and left brain to do its work, pointing out that the client can participate in EMDR by moving the eyes up and down, as opposed to right and left, and thus cancel out that supposed connection between the two hemispheres of the brain.

Regardless of the physical reason EMDR works, one thing is clear: It helps clients differentiate between what's important in the past and what's important now.

While CBT encompasses many different therapeutic techniques, Greenwald says it is focused mainly on management skills. On the flip side, EMDR transforms how people experience and react to their own memories. "I prefer EMDR because it's well tolerated and it's faster," Greenwald explains. He says once a client has completed EMDR therapy, he or she will find an ability to revisit a traumatic memory and not be bothered by it any longer.

Robinson says in her practice she has experienced an 80% to 90% success rate with EMDR, though she adds that because she is known for offering the treatment, many of her clients are highly motivated.

Who Is Best Suited for EMDR

"Just like everything, it works better with single-episode victims," Greenwald says. He says single-episode trauma can often be worked out in one EMDR session, especially if the client has a supportive family and has experienced a generally positive childhood.

While many researchers contend that EMDR is not appropriate for someone with seizure disorders, Greenwald says he believes just about anyone can be a candidate for the treatment. He says he would be reluctant to use it with children with autism because it can be physically distressing to them. But for most clients, he says, the real issue is, "Is the client well prepared?" EMDR needs to be part of a larger therapy. It is a phase model of treatment, and the client must be stable and in a safe place before beginning the process.

Robinson says EMDR isn't always the best option for children, even though it tends to work faster than other treatments, because children are often still in danger when they come in for therapy. "They have to be in a safe home and they have to trust you," she says. She says EMDR is also inappropriate when the client is hospitalized or on medication.

Twombly agrees, noting that a therapist shouldn't attempt EMDR with someone who is not stable, and it shouldn't be attempted with dissociative disorders unless the therapist has experience with dissociation. "Most of my clients have had over 30 years of treatment for trauma," she adds, "and they come to me because nothing else has worked."

She is quick to add, however, that EMDR won't work with people who don't have access to feelings. "People who are depressed or shut down won't respond to it," she says, because EMDR involves putting clients in touch with their emotions so they can overcome crippling reactions to traumatic memories.

How to Get Started

Greenwald advises EMDR practitioners to start their client off with something small and manageable as opposed to tackling an extremely traumatic experiences right away. "Sometimes it's best to start with the earliest memories and work your way forward," he says. "If the same thing happens over and

over again in someone's personal history, you don't have to go through every single memory. You can group similar experiences together."

Robinson essentially asks clients to put their traumatic memories in a container and then pull them out to look at bit by bit. Twombly says the container concept is a major reason she believes EMDR can work more quickly and effectively than PET, which reviews the same traumatic experiences repeatedly. "You don't want to take someone who has trauma on top of trauma and open that up all at once," she says. "This is where EMDR can help. It's given therapists a way to work with so many people who couldn't get through trauma in other ways."

— Deborah R. Huso is a freelance writer based in Blue Grass, VA, who writes frequently on youth, family, and social issues.

Case Study: Working Through EMDR with Children

Natalie Robinson, LICSW, who uses Eye Movement Desensitization and Reprocessing (EMDR) in her own practice and trains others in its use, says the best way to understand how the treatment works is to see it in action. Some years ago, she assisted with the case of a 10-year-old boy who had experienced one incident of molestation by a neighbor when he was 4 years old. While the child was treated six months after the incident occurred, he came back to his therapist with recurring symptoms at the age of 10. He couldn't sleep; yelled at noises in the house, including the television; and frequently seemed disturbed.

The boy's therapist came to Robinson, asking her to try EMDR with the child. As with all her clients, Robinson first walked the boy and his mother through the process of EMDR, explaining how it worked, and then she asked the boy to help her find a very safe place for him to go whenever an experience became too much for him. The child came up with diorama where he was protected by some of his favorite superheroes. As a first step, Robinson asked the boy to visualize himself in that safe place. Then she installed the image by using EMDR, making his eyes follow a light back and forth.

She then asked him and his mother to tell the story of his molestation, asking the boy to give her a hand signal whenever he needed to stop or go to his safe place. With the promise of receiving Batman-related items, the boy had been persuaded to go into a neighbor's basement. The 10-year-old's main issue was that he felt the incident was his fault, that it wouldn't have happened if he hadn't wanted the Batman paraphernalia. As Robinson walked the child through his experience, she asked him to consider where in his body he felt distress. "Other than that, I don't comment," she explains. "I just go with him on his journey."

Gradually, the boy worked through the pain of the episode, telling himself it wasn't his fault. "I'm only a kid," he said. Each time he reached a positive resolution, Robinson "installed" it with EMDR, asking him to follow the light with his eyes. She also found the boy was worried about the same thing happening to his little brother, but he decided he could tell his brother what to do in a similar instance. "I know what to do now," he told Robinson at the end of the session.

She asked the boy to come back for a second session, after which he experienced no more symptoms, according to his mother. "It's very rare that it goes off that well," Robinson adds. "Most people take a little longer, but he was a kid with a single incident and a supportive family."

— DRH

For more information on EMDR and opportunities for EMDR training, visit the EMDR International Association at www.emdria.org.